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Supreme Court, U.S.
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No. 00-151

In the Supreme Court of the United States

UNITED STATES OF AMERICA, PETITIONER

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE AND JEFFREY JONES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED: JULY 28, 2000
CERTIORARI GRANTED: NOVEMBER 27, 2000

163 pp

TABLE OF CONTENTS

Cases:	Page
Declaration of Laura A. Galli, R.N., dated Sept. 12, 1998, with Exhibits	1
Amended Declaration of Michael M. Alcalay, M.D., M.P.H., dated Sept. 30, 1998, with Exhibits	20
*Declaration of Michael M. Alcalay, M.D., M.P.H. dated May 29, 2000	40
Declaration of Special Agent Brian Nehring dated Jan. 8, 1998	46
Declaration of Special Agent Bill Nyfeler dated Jan. 8, 1998	52
Declaration of Special Agent Carolyn Porras dated Jan. 8, 1998	62
Declaration of Special Agent Deborah Muusers dated Jan. 8, 1998	68
Declaration of Special Agent Phyllis E. Quinn dated Dec. 23, 1997	74
Declaration of Special Agent Mark Nelson dated Jan. 8, 1998	77
Declaration of Robert Bonardi dated Sept. 10, 1998	80
Declaration of Willie C. Beal dated Oct. 15, 1998	84
Declaration of Albert Dunham dated Sept. 13, 1998	86
*Declaration of Terry Stogdell dated Apr. 27, 2000	89
*Declaration of Creighton W. Frost, Jr., dated Apr. 29, 2000	91

Table of Contents—Continued: Page

Declaration of Harold Sweet dated Sept. 10, 1998 93
** Declaration of Marcus A. Conant, M.D. dated Feb. 14, 1997 96
** Declaration of Howard D. MacCabee, Ph.D., M.D., dated Feb. 14, 1997 108
Declaration of John P. Morgan, M.D., dated Aug. 13, 1998 113
Declaration of Lester Grinspoon, M.D., dated Sept. 11, 1998 118
City of Oakland Ordinance No. 12076 dated July 28, 1998 138
Letter from Robert C. Bobb to Mr. Jeff Jones dated Aug. 11, 1998 145
Oakland City Council Resolution No. 74618 dated Oct. 27, 1998 147
Oakland City Council Resolution No. 75713 dated May 16, 2000 152

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* These materials were introduced by respondents in the district court on May 30, 2000, in support of respondents' motion to modify or dissolve preliminary injunction, following the Ninth Circuit's September 13, 1999 decision.

** These declarations were introduced in the district court by respondents on September 14, 1998, as attached to respondents' request for judicial notice, which the district court never acted upon.

Table of Contents—Continued: Page

Marijuana Arrests in California filed Sept. 19, 2000, in the Ninth Circuit as Exhibit B to Appellees' Request for Judicial Notice of Record in Prior Proceedings in the Ninth Circuits, Related Proceedings in the Supreme Court, and Certain Facts 158

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00089 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OF LAURA A. GALLI, R.N.

I, LAURA A. GALLI, declare:

1. I am one of two registered nurses who work at the Oakland Cannabis Buyers' Cooperative (the "Cooperative" or "OCBC"). As a staff nurse I am familiar with the policies and procedures of the OCBC. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. From 1990 through 1992 I worked as a student nurse intern and unit secretary in the Rehabilitation Unit at Mills-Peninsula Hospitals. During that time I

studied for my nursing degree at Cal-State Hayward, which degree I received in 1992. However, in July 1992 I was diagnosed with pleurisy and with lupus. This medical condition prevented me from being able to continue employment as a nurse. Currently I am an "inactive" registered nurse.

3. I work as a volunteer at the Cooperative as a staff nurse. The Intake Department of the Cooperative includes two staff nurses, one of whom is always on duty while the Cooperative is open on weekdays.

4. Before a patient is accepted for membership into the Cooperative, he or she must complete an extensive screening process. This process is described in detail in the Oakland Cannabis Buyers' Cooperative Protocols ("Protocols"), a copy of which is attached hereto as Exhibit 1. Before reaching my office, all applicants must satisfy the threshold requirement of providing authorization from a treating physician assenting to cannabis therapy for one or more medical conditions listed on the Medicinal Cannabis User Initial Questionnaire (Exhibit C to the Protocols).

5. If, upon screening by the Cooperative Intake staff member, the applicant cannot provide such authorization, he or she will be denied membership to the Cooperative.

6. Once the applicant provides a doctor's authorization for medical cannabis, it is my job to independently verify the physician's approval. No applicant is admitted to membership to the Cooperative unless and until I or the other staff nurse verify the applicant's physician's approval.

7. For each and every Cooperative applicant, either I or the other staff nurse telephone the applicant's doctor's office to verify the authenticity of the authorization submitted by the prospective member. I talk with the doctor (or in some instances a member of the doctor's staff) to confirm that the doctor did in fact authorize the use of cannabis for a medical condition. I also will confirm the date of the authorization. If the doctor or his staff cannot provide satisfactory responses to my questions, then I screen out the Cooperative applicant and reject the applicant for membership. A copy of the Verification of Physician's Written Recommendation form that I use is attached hereto as Exhibit 2.

8. For each and every doctor who has authorized the use of medical cannabis to one of the Cooperative applicants, either I or the other staff nurse confirm that the doctor is licensed to practice medicine in the State of California. If the doctor's credentials cannot be confirmed, then I reject the applicant for membership.

9. Soon after an applicant is admitted to membership in the Cooperative, he or she is issued a laminated membership card. A copy of a membership card is attached as Exhibit J to the Protocols. Each time a patient-member comes to the Cooperative, he or she must present this membership card along with secondary valid photo identification in order to gain entry.

10. I am familiar with the range of medical conditions from which the Cooperative's patient-members suffer. Patient-members of the Cooperative suffer from debilitating and often deadly diseases, including HIV and/or AIDS, cancer, arthritis, multiple sclerosis, and glaucoma. I know that medical cannabis provides relief

to patient-members as a pain reliever, an appetite stimulant, an anti-nauseant, and an anti-convulsant. Medical cannabis also relieves intraocular eye pressure in patient-members who suffer from glaucoma.

11. Although every patient's experience is unique, some general comments apply to many patients. For some Cooperative members, they have tried other legal medicines to alleviate their conditions but these other medicines do not work for them. For other members, other drugs have intolerable negative side effects which they have chosen not to endure. Some members' experiences with other legal medicines is that, while they are somewhat effective, they are not nearly as effective at relieving their symptoms as medical cannabis.

12. I have seen patient-members who suffer from AIDS-related "wasting syndrome" as well as those who have cancer and are undergoing chemotherapy and radiation therapy. Medical cannabis reduces nausea and increases appetite in these patients. Other medicines either do not work for some of these patients or they have serious adverse side effects that cannabis does not have. Supplying medical cannabis to these patient-members is necessary to avert imminent and potentially life-threatening harm.

13. I have also seen patient-members who suffer from multiple sclerosis or quadriplegia. They experience debilitating spasticity and/or constant pain. Other medicines simply do not work for many of these patient-members. These patients can also experience intolerable adverse side effects from other medications —side effects that cannabis does not have.

14. I suffer from both lupus and fibromyalgia. Lupus is a disease of the immune system which, among other things, causes an arthritic-type condition and arthritis-type pain. Fibromyalgia is a pain syndrome which affects the ligaments and tendons in all of my joints. I live in nearly-constant pain.

15. There are many medications I must take to treat my conditions. These medications have many adverse side effects, including stomach upset, chronic nausea and vomiting, and they can be addictive.

16. The doctors are not sure why I experience chronic nausea and vomiting. Over the years I have tried many medications and treatments to try to alleviate my nausea symptoms, but nothing worked for me.

17. Eventually, my primary care physician—Dr. Richard Morgan— authorized medical cannabis for my nausea and reduced appetite. This medicine has worked wonders for me. It has relieved my nausea and increased my appetite when nothing else would. Medical cannabis has had the additional benefit of helping to reduce my pain.

18. If I were forced to go without cannabis now I would be a mess—I would again have no appetite and would lose weight, I would experience a dramatic increase in nausea and vomiting, and the pain in my joints would increase. If the OCBC were forced to close down, I would in turn be forced to obtain cannabis on the criminal market. But at this point I would not know where to begin to look for cannabis. Resorting to the criminal market would make me seriously nervous for my safety.

19. In fact, many other patient-members' lives may be endangered if they were forced to try to obtain cannabis from criminal street dealers. This is in part because impurities in marijuana purchased on the street may be harmful to their health. It is also because it would be very dangerous for many of our patient-members to enter a high crime area which is where they would have to go to obtain cannabis. Some patient-members may choose to forego their medication if they have no choice but to turn to street dealers for cannabis.

20. The Cooperative, by contrast, provides a safe environment for patient-members to obtain their much needed medicine.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 12th day of September at Oakland, California.

/s/ LAURA A. GALLI, R.N.
LAURA A. GALLI, R.N.

EXHIBIT 1

Oakland Cannabis Buyers' Cooperative

Protocols

[Seal Omitted]

Compassion

Oakland Cannabis Buyers' Cooperative
Post Office Box 70401
Oakland, California 94612-0401
Tel. 510-832-5346
Fax 510-986-0534
Email ocbc@rxcbc.org
Web www.rxcbc.org

March 30 1998

Oakland Cannabis Buyers' Cooperative

Protocols

The Oakland Cannabis Buyers' Cooperative operates pursuant to and in accordance with the statewide mandate of Proposition 215 (Exhibit A) and Resolutions passed unanimously by the Oakland City Council and an Administrative Memorandum promulgated by the Chief of Police (Exhibit B). Its operating procedures have been consolidated as these Protocols.

I. Admission and Membership Requirements

A person seeking membership of the Oakland Cannabis Buyers' Cooperative must at the threshold provide a note from a treating physician assenting to cannabis therapy for a medical condition listed on the Medicinal Cannabis User Initial Questionnaire (Exhibit C). Upon acceptance of the note by Intake staff, the prospective member will undergo an extensive screening and such questioning as shall establish that the candidate meets the Medical Admissions Criteria (Exhibit D) including, without being limited to, the Oakland Cannabis Buyers' Cooperative Information Form (Exhibit E). If, upon the screening by Cooperative staff the candidate does not appear to qualify for membership, he or she will be denied membership with a statement of reasons for his/her being screened out. If the candidate appears to qualify for membership, Intake staff will give the candidate the Authorization for Release of Patient Status form (Exhibit F) and the Physician Statement (Exhibit G), with a request that the candidate's treating physician sign it. When the form is returned, the Intake staff will verify the physician's approval by independent telephone verification. Medical cannabis

cultivators and manufactures are issued cultivation and manufacturing Certificates (Exhibit H), which the City Council has approved to aid the Police in recognizing agents of the Cooperative.

No person under the age of eighteen shall be admitted to membership without the written consent of parents, in addition to meeting all other requirements.

II. Responsibilities of Membership

All members must sign a Membership Agreement (Exhibit 1), whereupon they will receive a Membership Card (Exhibit I). Members agree to conduct themselves discreetly, in accordance with the Statement of Safe Use of Cannabis (Exhibit K) and the Principles of Responsible Cannabis Use (Exhibit L).

III. Other Provisions

A. Purpose. The purpose of the Oakland Cannabis Buyers' Cooperative is to help provide medicine for people who need it. Accordingly, it shall be operated as a not for profit organization.

B. Privacy of members. The staff of the Cooperative shall take steps to protect the privacy and identity of members. However, neither the Cooperative nor its staff shall be liable for any breach thereof

C. Changes. These Protocols, and all medical protocols, are subject to change without notice from time to time in the sole discretion of management.

D. Cooperative operation.

a. No smoking of anything on premises.

b. Members shall observe additional house rules as same maybe posted by management.
c. Management may eject any person at any time.

Exhibits

A. Proposition 215

B. Oakland City Council Resolutions and Police Memorandum

C. Medicinal Cannabis User Initial Questionnaire

D. Medical Admissions Criteria

E. Information Form

F. Authorization for Release of Patient Status

G. Physician Statement

H. Cultivation and Manufacturing Certificates

I. Membership Agreement

J. Membership Card

K. Statement of Safe Use of Cannabis

L. Principles of Responsible Cannabis Use

Ex. E

OAKLAND CANNABIS BUYERS' COOPERATIVE

INFORMATION FORM [Seal Omitted]
(Please print clearly)

Compassion

Name_____

Street Address_____Apt. Number_____

City _____,State _____Zip Code_____

Phone Number (___) _____Date of Birth_____

Driver License #____State__Gender (M or F) _____

Caregiver _____DL# _____DOB_____

Physician's Name_____DX # _____

Address, City, State_____PHD# _____

Phone (_____) _____

Specific Diagnosis _____

_____ICD9 CODE_____

Medication(s)_____

_____

How do you use cannabis? Smoke hi grade_____
smoke lo grade_____edibles_____tinture_____

Are you politically active? _____

Member Signature	Date
Intake By	Member #

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401
Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534
Email ocbc@rxcbc.org Web www.rxcbc.org

Ex. F

OAKLAND CANNABIS BUYERS' COOPERATIVE

[Seal Omitted]

Authorization for Release of Patient Status
(Please print clearly)

Compassion

I,_____hereby authorize my treating
print patient name
physician, Dr._____to release to the
print patient name
Oakland Cannabis Buyers' Cooperative, my current patient status.

_____Date_____
Member/patient signature

Membership number_____

OAKLAND CANNABIS BUYERS' COOPERATIVE, P.O. Box 70401
Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534
Email ocbc@rxcbc.org Web www.rxcbc.org

Ex. G

Health and Safety Code 11362.5
PHYSICIAN'S STATEMENT

[Seal Omitted]
Compassion

This certifies that _____ is a patient under
print patient's name
my medical care and supervision for the treatment of _____.
Diagnosis

I have discussed the medical benefits and risks of cannabis use with the patient as a treatment for these medical conditions. I recommend cannabis use for my patient.

If my patient chooses to use cannabis therapeutically, I will continue to monitor his/her medical condition and to provide advice on his/her progress.

I understand that I may be contacted to verify the information in this letter. My patient authorizes me to discuss their medical condition and the contents of this letter, for verification purposes only. I am a physician licensed to practice medicine in the state of California.

_____
Patient's Signature

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (print) N.P./P.A. Signature (optional)

Physician's CA License No.

N.P./P.A. Name (optional-print)

(street)

(City)

( )

Phone Number

Certificate of Membership

This is to certify that on file with the undersigned officer of the Oakland Cannabis Buyers' Cooperative is a signed statement of a licensed Physician acknowledging and assenting to cannabis therapy for the patient identified on the reverse hereof, who, having satisfied all conditions of membership, is recognized as a Member in good standing of the

Oakland Cannabis Buyers' Cooperative

with all benefits and subject to all conditions as same shall from time to time be established by the Oakland CBC in accordance with its rules and Protocols. Presentation of this card shall be evidence that said patient's Physician would consider prescribing cannabis if he/she were legally able to do so, assents to the theraputic use, and has agreed to monitor and provide medical advice on the patient's progress.

Hours:

M & F 11am-7pm T, W, TH 11am-1pm, 5pm-7pm

Office # (510) 832-5346

24 hr Emergency voicemail/ pager service (for Law Enforcement use only) 1-888-340-1260.

_____

JEFFREY W. JONES
Executive Director

Oakland Cannabis
Buyers' Cooperative
[Seal Omitted]
Compassion

OAKLAND CANNABIS BUYERS' COOPERATIVE
Health and Safety Code 11362.5
VERIFICATION OF PHYSICIAN'S WRITTEN RECOMMENDATION

_____ _____

Patient's Name (printed) Membership Number

I have documents stating the physician indicated below attests that:

__He/She is aware of this patient's use of medical cannabis.

__He/She has discussed the risks and benefits of cannabis use with this patient.

__He/She will monitor the use of medical cannabis for this patient.

__He/She recommends or approves the use of medical cannabis for this patient.

OR

He/She recommends <u>against</u> medical cannabis for this patient.

Verification Information was provided by_____ on____ at____

__ Office staff at physician's phone number

__ Direct discussion with physician

__ Nurse at physician's phone number

__Nurse practitioner or physician's assistant at physician's phone number

---

Physician's Name	Date seen by Physician
Address	M.D. Specified Expiration Date (optional)
	CA License No. (obtain by phone)
( ) Phone	License Expiration Date
ICD9 Code	

I have verified this physician's California License as current and valid by checking with the California Board of Medical Quality Assurance. Date verified:_____

Employee's Name	Employee's Signature

OAKLAND CANNABIS BUYERS' COOPERATIVE, P. O Box 70401
Oakland, CA 94612-0401
Phone (510) 832-5346 Fax (510) 986-0534
Email ocbc@rxobc.org Web www.rxobc.org

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

[Filed: Sept. 30, 1998]

AMENDED DECLARATION OF
MICHAEL M. ALCALAY, M.D., M.P.H.

I, MICHAEL M. ALCALAY, declare:

1. I am Medical Director of the Oakland Cannabis Buyers' Cooperative (the "Cooperative" or "OCBC"). As Medical Director I am familiar with the policies and procedures of the OCBC. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I am a Board-certified pediatrician. I graduated from U.C.L.A. medical school in 1968. I received a Masters Degree in public health in 1973 from the University of California Berkeley School of Public Health. I practiced as a pediatrician in the Northern California Kaiser Hospitals until 1995 when I became ill.

3. In addition to my work as a physician, from 1987 through 1993, I was also an award winning producer of a nationally syndicated weekly medical program entitled "AIDS in Focus".

4. As Medical Director of the Cooperative I attend regular board meetings and consortium meetings. Other duties include acting as liaison between the Cooperative and patient-members' authorizing physicians. As a result of my duties as Medical Director, I am knowledgeable about many Cooperative patients and their medical conditions. On May 21, 1998, I was present at the Cooperative at the time of the scheduled press conference.

5. I am also a patient-member of the Cooperative. I learned I was HIV-positive in 1986. I was first diagnosed with AIDS in 1993. In 1995, I became very seriously ill with an AIDS-related condition called cryptosporidium. I contracted this disease from drinking the local water supply. Cryptosporidium caused me to have constant diarrhea, I experienced a dramatic loss of my appetite, and I also suffered generally from apathy. I rapidly lost thirty pounds as I dropped from weighing 165 pounds to 135 pounds. At one point visiting nurses came regularly to my home so that I could be fed intravenously. I was suffering from the classic "wasting syndrome" that is associated with many AIDS patients.

6. When I eventually medicated myself with cannabis, I regained my appetite, and I was finally able to regain weight again. The cannabis kept me alive until a therapy could be found to eradicate the microbe from my body. The cannabis also caused a dramatic improvement in my spirits. I have since recovered from a very serious and life-threatening illness.

7. I have been required to take a lot of different medications to treat my AIDS condition, including the drug AZT and a variety of different protease inhibitors. I need these medications in order to live. But these medicines cause nausea and vomiting. To combat the nausea I have tried several prescription drugs including Marinol and Atarax, but none of them have worked for me. Marinol did not work well for me at all because it was nearly impossible to time its effect or to achieve the right dosage. It would take up to an hour or more to take effect, and I had trouble finding the correct dosage as a result of this long lag time in its kicking in. Atarax was not as effective as cannabis in alleviating my nausea.

8. Cannabis has been the only medicine that has worked for me to control the nausea and vomiting caused by my AIDS medications. It starts to provide relief after only a few minutes of inhaling just a little bit.

9. The goal of the Cooperative is to provide seriously ill patients with a safe and reliable source of medical cannabis products and plants. The Cooperative is open to all patients with a verifiable letter of diagnosis and recommendation or approval from a doctor for medical cannabis use. A complete Mission Statement is

attached to the Declaration of James D. McClelland as Exhibit 1.

10. The Cooperative consists of one class of patient-members. According to the Cooperative's Bylaws, to qualify for membership an applicant must comply with the Protocols of the Oakland Cannabis Buyers' Cooperative. A copy of the OCBC Bylaws and Articles of Incorporation is attached to the Declaration of James D. McClelland as Exhibit 2.

11. Before a patient is accepted for membership into the Cooperative, he or she must complete an extensive screening process. This process is described in detail in the Oakland Cannabis Buyers' Cooperative Protocols ("Protocols"), a copy of which is attached to the Declaration of James D. McClelland as Exhibit 3.

12. According to the stated policies and procedures of the Cooperative, all applicants first must satisfy the threshold requirement of providing authorization from a treating physician assenting to cannabis therapy for one or more medical conditions listed on the Medicinal Cannabis User Initial Questionnaire (Exhibit C to the Protocols). Upon acceptance of the doctor's note by Intake staff, the prospective member undergoes an extensive screening process to determine whether the applicant meets the Medical Admissions Criteria (Exhibit D to the Protocols). Each applicant must fill out and submit the Cooperative Information Form (Exhibit E to the Protocols).

13. If, upon screening by the Cooperative Intake staff member the applicant does not qualify for membership, he or she will be denied membership to the Cooperative.

14. If the applicant does appear to qualify for membership, a staff nurse must independently verify the physician's approval of cannabis use. It is the OCBC's policy and practice that an applicant not be admitted to membership in the Cooperative unless and until the applicant's physician's approval is verified by the staff nurse.

15. The Cooperative schedules a staff nurse to be on duty throughout every weekday business hour of the Cooperative.

16. Shortly after an applicant is admitted to membership in the Cooperative, he or she is issued a laminated membership card. A copy of a membership card is attached as Exhibit J to the Protocols. Each time a patient-member comes to the Cooperative he or she must present this membership card along with secondary valid photo identification.

17. Each time a patient-member comes to the Cooperative to receive medicine, the patient-member must pass three separate security check-points. At each of the check-points the member must present two forms of identification described in paragraph 17. First, the member must present identification to a security guard at the front door to the Cooperative. Second, a second security guard examines the member's identification at the member room door leading into the sales area of the Cooperative. Finally, a Cooperative staff member always checks the patient-member's identification again at the point of sale.

18. I am personally aware that patient-members of the Cooperative suffer from debilitating and often deadly diseases, including HIV and/or AIDS, cancer,

arthritis, multiple sclerosis, and glaucoma—to name a few. I have seen and am aware that medical cannabis provides relief to patient-members as a pain reliever, an appetite stimulant, an anti-nauseant, and as relief from spasticity. Medical cannabis relieves intraocular eye pressure in patient-members who suffer from glaucoma.

19. As Medical Director, I have reviewed and am generally familiar with the medical circumstances that have led Cooperative members to seek medical cannabis. Although every patient's experience is unique, some general comments apply to many patients. Some Cooperative members have tried other legal medications to alleviate their conditions, but these other medications do not work for them. For other members, other medications have intolerable negative side effects they have chosen not to endure. Some members' experiences with other legal medications is that, while they are somewhat effective, they are not nearly as effective at relieving their symptoms as medical cannabis.

20. I am aware that Cooperative patient-members suffering from AIDS-related "wasting syndrome" (including myself) and those with cancer undergoing chemotherapy experience nausea and severe appetite deficits. Patients such as myself suffer these same conditions also as a result of having to take multiple medications to treat AIDS, some of them new or experimental. I am aware that medical cannabis relieves these symptoms in patients and enables them to eat. Medical cannabis prolongs some of these patients' lives (including my own). Cannabis enables these patients to take the other medications (in the case of AIDS

patients) or to continue to undergo the intensive chemotherapy (in the case of cancer patients) in order to stay alive. For these patients, other medicines either do not work at all (or they are not nearly as effective as medical cannabis) or they cause severe adverse side effects that medical cannabis does not cause. I believe, based on personal experience, that supplying medical cannabis to these patient-members is necessary to avert imminent and often life-threatening harm.

21. I am aware that the patient-members who suffer from multiple sclerosis or quadriplegia experience debilitating spasticity and/or constant pain. Unless medicated these patients will be forced to live with uncontrollable muscular spasticity or to endure debilitating pain throughout every day. For many of these patients, other medications or treatments either do not work at all, they are not nearly as effective as medical cannabis, or they cause severe adverse side effects that medical cannabis does not cause. Thus, many of these patient-members have no reasonable alternative to medical cannabis.

22. On May 21, 1998, approximately 191 patients came to the Cooperative. Sixty-six percent of the patients who came to the Cooperative suffered from HIV and/or AIDS, 4 % of patients who came to the Cooperative suffered from cancer, 2 % of patients who came to the Cooperative suffered from glaucoma, 1 % of patients who came to the Cooperative suffered from multiple sclerosis, and almost 20 % of patients who came to the Cooperative suffered from disorders involving chronic pain, such as quadriplegia.

23. For each and every patient-member who came to the Cooperative on May 21, 1998, there exists in the

OCBC files written confirmation that a treating California physician acknowledged and assented to cannabis therapy to treat the patient's medical condition or conditions.

24. The OCBC maintains, in the normal course of business, a database which contains information concerning its patient-members, including their diagnosis. I am familiar with the manner in which this information is gathered and entered into the database. Intake workers and volunteers who are qualified to do so, review documents in the patient's file, including personal information provided by the patient, the intake questionnaire containing the patient's diagnosis, and the information confirming that a licensed California doctor has made the diagnosis and has recommended the use of medical cannabis. Information concerning the diagnosis, the IC-9 (a standardized code used by physicians to classify a patient's medical condition), as well as the patient's name and treating physician are entered into the computer. Attached hereto as Exhibit A is a true and correct copy of a printout from OCBC's database concerning the patients who were present at the Cooperative on May 21, 1998. This printout contains the patient's identification number, the patient's specific diagnosis, and the IC-9 code.

25. Numerous attempts have been made to obtain sworn declarations of patient-members who came to the Cooperative on May 21, 1998. Many of these patients, however, are afraid to sign any declaration as a result of the federal government's announced intention not to immunize any such declarations offered in this proceeding from use in any possible subsequent criminal proceedings. Many of these patients would sign declar-

ations detailing for the Court their medical condition and their dire need of medical cannabis to alleviate their condition if these statements were immunized.

26. One of the patient-members who came to the Cooperative on May 21, 1998, is now deceased. She died from cancer.

27. I have reviewed and am familiar with the medical records and OCBC files relating to the patients who visited the Cooperative on May 21, 1998. Numerous California physicians have rendered a medical opinion approving cannabis treatment for these patients.

28. Many patient-members' lives may be put in jeopardy if they were forced to try to obtain cannabis from criminal street dealers. This is what would happen if the OCBC were forced to close down. They may be placed in danger both because the act of purchasing from street dealers is inherently dangerous and because impurities in marijuana purchased on the street may be harmful to their fragile health. There is also the danger that this method of obtaining cannabis will certainly lead to exposure to dangerous drugs sold on the street, which may in turn lead to temptations or opportunities which have no place at the OCBC. Some patient-members may choose to forego their medication if they have no choice but to turn to street dealers for cannabis.

29. The patient-members of the Cooperative are joint participants in a cooperative effort to obtain and share medical cannabis. Patient-members of the Cooperative jointly acquire marijuana for medical purposes to be shared among themselves and not with anyone

else. No third persons are involved other than "primary caregivers" who are responsible for the housing, health, or safety of the patient. Any payment made to the Cooperative constitutes reimbursement for administrative expenses and operations which all patient-members who utilize the services of the Cooperative agree to share. Attached to the Declaration of James D. McClelland as Exhibit 4 is a true and correct copy of the Oakland Cannabis Buyers' Cooperative Statement Of Conditions under which each and every member agrees to receive his or her medicine.

30. The Cooperative prohibits the smoking of cannabis on its premises; therefore, patient-members who smoke medical cannabis cannot immediately consume their medicine in the presence of other patient-members.

31. Last month, the City of Oakland designated the Oakland Cannabis Buyers' Cooperative to administer the City's Medical Cannabis Distribution Program. Attached to the Declaration of James D. McClelland as Exhibit 5 is a true and correct copy of this designation along with supporting documents which helped satisfy the City of Oakland that the Cooperative is a bona fide corporation safely and lawfully engaged in activities benefiting the citizens of Oakland

32. I understand and believe that currently the federal government will not enroll any additional patients in any federal program studying the medical use of cannabis.

33. I understand and believe that currently pending are petitions to reschedule medical cannabis from Schedule I to Schedule II of the Controlled Substances

Act, but that none of these petitions have yet been granted.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 30th day of September at San Francisco, California.

/s/ MICHAEL M. ALCALAY
MICHAEL M. ALCALAY

EXHIBIT A

Combined Summary

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	2	Carcinoma of Rt. Lung	162.9
5/21/98	7	ARC, Epilepsy, Stress	042.
5/21/98	7	ARC, Epilepsy, Stress	042.
5/21/98	19	HIV	042.
5/21/98	26	HIV	042.
5/21/98	31	HIV	042.
5/21/98	32	Arthritis	716.90
5/21/98	36	AIDS	042.
5/21/98	38	HIV	042.
5/21/98	39	Back pain, Dorsal Kyphosis	732.8
5/21/98	52	Severe Anxiety	300.00
5/21/98	65	AIDS	042.
5/21/98	82	HIV	042.
5/21/98	92	Meniere's Disease	386.0
5/21/98	110	Paranoid Schizophrenia	295.9
5/21/98	124	Cervical Spondylosis	755.9
5/21/98	138	Epididymitis	604.90
5/21/98	139	AIDS	042.
5/21/98	166	AIDS	042.
5/21/98	167	AIDS	042.
5/21/98	167	AIDS	042.
5/21/98	168	HIV	042.
5/21/98	172	AIDS	042.
5/21/98	174	AIDS	042.
5/21/98	175	HIV	042.
5/21/98	177	HIV	042.
5/21/98	186	Paralysis Lower Extremities (Polio)	344.9

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	189	Acute Anxiety, Depression	295.9
5/21/98	190	HIV	042.
5/21/98	193	AIDS	042.
5/21/98	195	AIDS	042.
5/21/98	198	AIDS	042.
5/21/98	207	Bipolar Disorder	296.4
5/21/98	210	AIDS	042.
5/21/98	212	Thyroid Carcinoma	226.
5/21/98	212	Thyroid Carcinoma	226.
5/21/98	213	Scoliosis, Back Pain	737.30
5/21/98	215	Glaucoma	365.9
5/21/98	219	Neuropathy Entrapment	355.9
5/21/98	229	HIV	042.
5/21/98	246	AIDS	042.
5/21/98	248	Glaucoma	365.9
5/21/98	252	AIDS	042.
5/21/98	265	AIDS	042.
5/21/98	284	AIDS	042.
5/21/98	284	AIDS	042.
5/21/98	297	HIV	042.
5/21/98	297	HIV	042.
5/21/98	304	HIV	042.
5/21/98	313	AIDS	042.
5/21/98	317	AIDS	042.
5/21/98	358	AIDS	042.
5/21/98	359	HIV	042.
5/21/98	374	Amputation	897.4
5/21/98	382	HIV	042.
5/21/98	388	HIV	042.
5/21/98	404	AIDS	042.

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	410	Lumbar Strain	-724.0
5/21/98	410	Lumbar Strain	724.0
5/21/98	451	HIV	042.
5/21/98	472	Lung Cancer	162.9
5/21/98	492	AIDS	042.
5/21/98	495	AIDS	042.
5/21/98	502	AIDS	042.
5/21/98	510	AIDS	042.
5/21/98	514	Multiple Sclerosis	340.
5/21/98	565	HIV	042.
5/21/98	571	Multiple Herniated Discs	722.6
5/21/98	578	Hepatitus C, Cerviel DTD Seizure D	715.00
5/21/98	586	AIDS	042.
5/21/98	587	Cluster Migrains	346.10
5/21/98	606	AIDS	042.
5/21/98	620	Neurofibromatosis	237.7
5/21/98	654	AIDS	042.
5/21/98	654	AIDS	042.
5/21/98	654	AIDS	042.
5/21/98	661	HIV	042.
5/21/98	664	HIV	042.
5/21/95	674	AIDS	042.
5/21/98	674	AIDS	042.
5/21/98	677	AIDS	042.
5/21/98	686	HIV	042.
5/21/98	697	AIDS	042.
5/21/98	735	Muscle Spasm, Gastritis	728.85
5/21/98	735	Muscle Spasm, Gastritis	728.85
5/21/98	746	AIDS	042.

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	756	AIDS	042.
5/21/98	759	HIV	042.
5/21/98	763	Glaucoma	365.11
5/21/98	788	Diabetic Neuropathy	250.0
5/21/98	801	Musculoskeletal Hip Pain	729.81
5/21/98	803	AIDS	042.
5/21/98	816	AIDS	042.
5/21/98	826	AIDS	042.
5/21/98	832	HIV	042.
5/21/98	839	HIV	042.
5/21/98	848	Depression	300.4
5/21/98	866	AIDS	042.
5/21/98	871	AIDS	042.
5/21/98	888	AIDS	042.
5/21/98	892	HIV	042.
5/21/98	898	HIV	042.
5/21/98	900	AIDS	042.
5/21/98	901	Multiple Sclerosis	340.
5/21/98	902	AIDS	042.
5/21/98	908	AIDS	042.
5/21/98	940	HIV	042.
5/21/98	966	AIDS	042.
5/21/98	968	AIDS	042.
5/21/98	969	AIDS	042.
5/21/98	972	AIDS	042.
5/21/98	994	AIDS	042.
5/21/98	998	HIV	042.
5/21/98	998	HIV	042.
5/21/98	1003	HIV	042.
5/21/98	1003	HIV	042.

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	1007	AIDS	042.
5/21/98	1027	AIDS	042.
5/21/98	1028	HIV	042.
5/21/98	1031	AIDS	042.
5/21/98	1031	AIDS	042.
5/21/98	1033	AIDS	042.
5/21/98	1035	HIV	042.
5/21/98	1035	HIV	042.
5/21/98	1056	Anxiety Disorder	300.5
5/21/98	1089	Spondylosis Cervical Severe	720.9
5/21/98	1103	Depression	
5/21/98	1123	HIV	042.
5/21/98	1126	AIDS	042.
5/21/98	1128	HIV	042.
5/21/98	1135	Paranoid Schizoophrenio	295.4
5/21/98	1175	AIDS	042.
5/21/98	1195	Arthritis	716.5
5/21/98	1195	Arthritis	716.5
5/21/98	1214	HIV	042.
5/21/98	1215	AIDS	042.
5/21/98	1220	AIDS	042.
5/21/98	1223	AIDS	042.
5/21/98	1233	AIDS	042
5/21/98	1244	Migrane	365.9
5/21/98	1247	Macular Degeneration	362.50
5/21/98	1252	Severe Spinal Strain	729.9
5/21/98	1252	Severe Spinal Strain	729.9
5/21/98	1255	Cancer	
5/21/98	1285	Fibrorhyalia/Depression	
5/21/98	1286	AIDS	042.

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	1289	AIDS	042.
5/21/98	1301	AIDS	042.
5/21/98	1305	AIDS	042.
5/21/98	1307	AIDS	042.
5/21/98	1315	AIDS	042.
5/21/98	1317	General Anxiety Disorder	304.0
5/21/98	1319	HIV	042.
5/21/98	1324	Rotator Cuff Syndrome	
5/21/98	1341	Disabling HIV	042.
5/21/98	1352	Cervical Cancer	233.1
5/21/98	1359	Nausia	787.02
5/21/98	1392	PGW Syndrome, Fibromalgia	729.1
5/21/98	1392	PGW Syndrome, Fibromalgia	729.1
5/21/98	1421	Dysthimic Disorder	300.4
5/21/98	1422	AIDS	042.
5/21/98	1423	Chronic Pain from Degenerative Joint	
5/21/98	1429	AIDS	042.
5/21/98	1433	AIDS	042.
5/21/98	1433	AIDS	042.
5/21/98	1444	AIDS	042.
5/21/98	1444	AIDS	042.
5/21/98	1452	AIDS	042.
5/21/98	1455	Chronic Pain	
5/21/98	1472	AIDS	042.
5/21/98	1474	AIDS	042.
5/21/98	1493	AIDS	042.
5/21/98	1498	AIDS	042.

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	1512	Nuerological [*sic*] Anoymoly	345.9
5/21/98	1517	Post Traumatic Arthritis	716.
5/21/98	1519	AIDS	042.
5/21/98	1522	HIV	042.
5/21/98	1534	Stress/Depression	300.4
5/21/98	1538	AIDS	042.
5/21/98	1541	HIV	042.
5/21/98	1567	HIV	042.
5/21/98	1598	Chronic Pain –Arthritis – Depression	716
5/21/98	1599	Generalized Anxiety Disorder	300.0
5/21/98	1602	Arthiritis	716
5/21/98	1607	Chronic Pain	724.0
5/21/98	1612	HIV Disabling	042.
5/21/98	1613	Arthiritis	716.94
5/21/98	1620	Arthritic—Lim Pain	721.90
5/21/98	1621	H.I.V.	042.
5/21/98	1628	AIDS	042.
5/21/98	1633	AIDS	042.0
5/21/98	1635	H.I.V.	042.0
5/21/98	1657	H.I.V.	042.
5/21/98	1658	Dysthmia	
5/21/98	1660	Arthiritis	716.5
5/21/98	1662	H.I.V.	042.
5/21/98	1663	AIDS	042.
5/21/98	1663	AIDS	042.
5/21/98	1665	Pain and Headaches	
5/21/98	1670	Back Pain, T-Spine	724.1
5/21/98	1675	Scholiosis	754.2

Date	Member#	Specific Diagnosis	ICD-9-CM
5/21/98	1676	AML Leukemia	204.0
5/21/98	1701	AIDS	042.
5/21/98	1705	Endometriosis, Chronic Pelvic Pain	

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-0088 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OF MICHAEL M. ALCALAY, M.D., M.P.H. IN SUPPORT OF MOTION TO DISSOLVE OR MODIFY PRELIMINARY INJUNCTION ORDER

I, MICHAEL M. ALCALAY, M.D., declare:

1. I am Medical Director of the Oakland Cannabis Buyers' Cooperative (the "Cooperative" or "OCBC"). As Medical Director I am familiar with the policies and procedures of the OCBC. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I am a Board-certified pediatrician. I graduated from U.C.L.A. medical school in 1968. I received a Masters Degree in public health in 1973 from the University of California Berkeley School of Public Health. I practiced as a pediatrician in the Northern California Kaiser Hospitals until 1995 when I became ill with an AIDS related illness.

3. As Medical Director of the Cooperative I attend regular board meetings and consortium meetings. Other duties include acting as liaison between the Cooperative and patient-members' authorizing physicians and doing patient outreach. As a result of my duties as Medical Director, I am knowledgeable about many Cooperative patients and their medical conditions.

4. Since October 20, 1998, the OCBC has not engaged in the manufacture or distribution of cannabis from its premises, or used the premises for the purpose of manufacturing or distributing cannabis. The OCBC has remained open for limited purposes including: conducting support groups for patients suffering from a variety of medical conditions; providing massage therapy for patient-members; conducting member intake procedures and verifying physician recommendations and approvals; issuing identification cards on behalf of the City of Oakland pursuant to Oakland municipal law; conducting meetings regarding medical cannabis research; providing meals for patient-members; furnishing a meeting space for various community groups; selling books and T-shirts; responding to telephone inquiries regarding medical cannabis issues; and administrative activities.

5. As Medical Director, I have reviewed and am generally familiar with the medical circumstances that have led patient-members to seek medical cannabis. I have witnessed the devasting effect of the OCBC's inability to provide cannabis to these members.

6. I am personally aware that patient-members of the Cooperative suffer from debilitating and often

deadly diseases, including HIV and/or AIDS, cancer, arthritis, multiple sclerosis, and glaucoma—to name a few. I have seen and am aware that medical cannabis provides relief to patient-members as a pain reliever, an appetite stimulant, an anti-nauseant, and as relief from spasticity. Medical cannabis relieves intraocular eye pressure in patient-members who suffer from glaucoma. Patient-members who have not been able to receive cannabis have been unable to eat, have suffered excruciating pain and debilitating side effects. Some have died.

7. I am also a patient-member of the Cooperative. I learned I was HIV-positive in 1986. I was first diagnosed with AIDS in 1993. In 1995, I became very seriously ill with an AIDS-related condition caused by a microbe called cryptosporidium that caused me to have constant diarrhea. I experienced a dramatic loss of my appetite, and I also suffered generally from apathy. I was suffering from the classic "wasting syndrome" that is associated with many AIDS patients. When I eventually medicated myself with cannabis, I regained my appetite, and I was finally able to regain weight again. The cannabis kept me alive until a therapy could be found to eradicate the microbe from my body.

8. I have been required to take a lot of different medications to treat my AIDS condition, including the drug AZT and a variety of different protease inhibitors. I need these medications in order to live. But these medicines cause nausea and vomiting. To combat the nausea I have tried several prescription drugs including Marinol and Atarax, but none of them have worked for me. Cannabis has been the only medicine that has

worked for me to control the nausea and vomiting caused by my AIDS medications.

9. I am aware that patient-members (including myself) suffer from serious medical conditions such as AIDS-related "wasting snydrome" and those with cancer undergoing chemotherapy experience nausea and severe appetite deficits. Patients, such as myself, also suffer these same conditions as a result of having to take multiple medications to treat AIDS, some of them new or experimental. I am aware that medical cannabis relieves these symptoms in patients and enables them to eat. Medical cannabis prolongs some of these patients' lives (including my own). Without the necessary cannabis, patients are unable to take the other medications (in the case of AIDS patients) or to continue to undergo the intensive chemotherapy (in the case of cancer patients) in order to stay alive. If the patients do not have access to cannabis these patients will suffer imminent harm. Cannabis is necessary for the treatment of these patients' medical conditions. For some of these patients cannabis will alleviate the medical condition or symptoms associated with it. For these patients, there is no legal alternative to cannabis for the effective treatment of the patients' medical condition because the patients have tried legal alternatives to cannabis and have found them ineffective in treating his or her condition, or have found that such alternatives result in intolerable side effects. Thus, these patients have no reasonable alternative to medical cannabis. I believe, based on personal experience, that supplying medical cannabis to these patient-members is necessary to avert imminent and often life-threatening harm.

10. I am aware that the patient-members suffer from serious medical conditions such as multiple sclerosis or quadriplegia. These patient-members experience debilitating spasticity and/or constant pain. If these patients do not have access to cannabis these patients will suffer imminent harm such that they are forced to live with uncontrollable muscular spasticity and to endure debilitating pain throughout every day. Cannabis is necessary for the treatment of these patients' medical condition. For some of these patients, cannabis will alleviate the medical condition or symptoms associated with the multiple sclerosis or quadriplegia. For these patients, there is no legal alternative to cannabis for the effective treatment of the patients' medical condition because the patients have tried legal alternatives to cannabis and have found them ineffective in treating his or her condition, or has found that such alternatives result in intolerable side effects. Thus, these patient-members have no reasonable alternative to medical cannabis. I believe that supplying medical cannabis to these patient-members is necessary to avert imminent and often-life threatening harm.

11. Patient-members have been forced to endure further harm by the OCBC's inability to provide medical cannabis. Several of the patient-members are now deceased. They died from illnesses including cancer, AIDS, and cachexia. Patient-members John Odell, Elizabeth Schoen, Willie Beal, Paul Allen, Miles Sanders and Walter Hatchett have died. Access to medical cannabis may have offered them a chance at recovery, minimized their suffering, or even prolonged their life.

12. Many patient-members' lives have been jeopardized since the preliminary injunction was issued. Patient-members have been forced to try to obtain cannabis from alternative and unsafe sources. They are placed in danger both because the act of purchasing from unauthorized sources such as street dealers is inherently dangerous and because impurities in marijuana purchased on the street may be harmful to their fragile health. Some patient-members have chosen to forego their medication altogether because of the severe and harmful risks associated with these alternative sources. These patients have faced months of needless pain and worsening of the severe symptoms associated with their illnesses. Some of these patients even face death because they do not have safe lawful access to medical cannabis.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 29th day of May, 2000, at Oakland, California.

/s/ MICHAEL M. ALCALAY, M.D., M.P.H.
MICHAEL M. ALCALAY, M.D., M.P.H.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

No. C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE,
AND JEFFREY JONES, DEFENDANTS

[Filed Jan 9, 1998]

DECLARATION OF SPECIAL AGENT
BRIAN NEHRING

I, BRIAN NEHRING, do hereby declare and say as follows:

1. I am a Special Agent with the San Francisco Field Division of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since September 1991.

2. I have received training from the DEA and Federal Bureau of Investigation in specialized narcotic investigative matters including, but not limited to, the following: drug interdiction and detection, money laundering techniques and schemes, drug identification, and asset identification and forfeiture. This training included specialized training in the preparation of nar-

cotic and document search warrants for residences and businesses.

3. I have participated in numerous investigations specifically involving both the indoor and outdoor manufacture or cultivation of marijuana. In the course of these investigations, I have personally participated in the eradication of over 1,000 indoor and 10 outdoor marijuana plants, and the arrest of more than 100 individuals for violations of federal and state law regarding controlled substances. I also have received specialized training regarding the techniques used to grow marijuana. Based on my experience and training, I am familiar with the smell and appearance of growing and processed marijuana, as well as the smell of marijuana when it is burning. I also have participated in the obtaining and/or execution of over 100 federal and California state warrants to search a particular place or premises for controlled substances and/or related paraphernalia, indicia, and other evidence of the commission of state and/or federal felony violations of law.

4. On May 19, 1997, I made an undercover purchase of one-eighth ounce of marijuana with the brand name of "Northern Lights" for $40 from the Oakland Cannabis Buyer's Cooperative ("OCBC"), a marijuana distribution business located at 1755 Broadway Avenue, in Oakland, California. I made this undercover purchase using an undercover name, identification, and a phony physician statement. The circumstances of this undercover purchase are as follows:

5. On May 19, 1997, I was provided with Official Authorized Funds and a phony physician statement, in anticipation of making an undercover purchase of mari-

juana from the OCBC. The phony physician statement used my undercover identity as the patient's name, and stated that this person suffered from "Post-Traumatic Stress Disorder." The marijuana distribution center designated was the "Oakland CBC." The doctor listed on the statement also was a phony identity. A telephone number for the doctor listed on the statement was for an undercover telephone line to the DEA San Francisco.

6. At approximately 1:55 p.m., I approached the entrance of the OCBC and entered into a small lobby area which led to an elevator and staircase, where a unidentified adult male dressed as a uniformed security guard was seated behind a desk. The guard informed me that he would have to see my identification and physician statement, which I produced. The guard then directed me to the third floor of the building and told me to take the staircase, being that the elevator did not work. I walked up the staircase to the third floor of 1755 Broadway Avenue, along with three other apparent OCBC customers.

7. Upon reaching the third floor, I was met by an unidentified adult male ("UM1") who gave me a form to fill out and took my physician statement to another room at the rear of the floor. The form I was handed, when blank, asked for the customer's name, address, phone number, physician's name, illness, what illnesses or conditions the customer had suffered from, what medications the customer was taking, whether the customer had ever used marijuana before, and how the customer had used marijuana before (smoked, eaten, etc.). I completed the form using my undercover

identity, and listed "Post Traumatic Stress Disorder" as my ailment.

8. While completing this form, I observed two small children, approximately 2-4 years of age, in the company of an adult who appeared to be working for the OCBC.

9. UM1 then led me down a hallway to a room where I was interviewed by another adult male who introduced himself as "Jim." "Jim" told me that, although the OCBC had not been able to contact "Dr. Eastwood," my forms appeared acceptable. "Jim" then gave me an OCBC membership card. The front of the card contains the OCBC symbol on the left, the OCBC's name on the right, and blank listings for the customer's membership number and name. The customer's name was filled in with my undercover identity. The back of the card lists the OCBC's hours as 11:00 a.m. to 7:00 p.m. on Monday and Friday, and 11:00 a.m. to 1:00 p.m., and 5:00 p.m. to 7:00 p.m., from Tuesday through Thursday, and contains blank listings for the customer's name, address, and phone number. My undercover identity was again listed on the back of the card, along with an undercover address and telephone number. The membership card did not contain picture identification.

10. "Jim" then led me down a hallway to a room which "Jim" referred to as the "bar room." In this room, I observed two individuals standing behind a large glass display case containing numerous samples of marijuana. I also observed an adult male smoking marijuana while sitting in a chair on the opposite side of the room. The smell of burning marijuana was readily

apparent. This individual was sitting next to a display case which contained two large growing marijuana plants under lights, and I also observed several large marijuana plants growing in a Mylar-lined display case at the opposite corner of the room.

11. "Jim" informed me that I would be able to purchase one-quarter ounce of marijuana per visit, and then introduced me to an unidentified adult male ("UM2") who was in charge of distributing the marijuana. UM2 informed me that the OCBC currently had seven kinds of marijuana for sale, all displayed, which he claimed ranged in price from between $28 to $85 per one-eighth ounce. UM2 also said that the OCBC was sold out of the Mexican-grown marijuana, which ordinarily sold for $28 per one-eighth ounce.

12. I then purchased one-eighth ounce of what the OCBC identified as marijuana with the "brand name" of "Northern Lights" for $40.

13. At approximately 2:25 p.m., I exited the OCBC, and subsequently met with two fellow Special Agents at a designated rendezvous location, whereupon I turned over the bag of suspected marijuana to these agents for evidentiary purposes.

14. The bag of suspected marijuana which I purchased from the OCBC on May 19, 1997, was subsequently marked as Exhibit 11, and transferred to the DEA Western Regional Laboratory for analysis.

15. During this visit to the OCBC to establish membership, I did not observe any other commercial

activity ongoing at the OCBC except for the distribution of marijuana.

I declare under penalty of perjury that the foregoing is true and correct.

/s/ BRIAN NEHRING
BRIAN NEHRING

Executed this 5th day of January 1998

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

No. C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE,
AND JEFFREY JONES, DEFENDANTS

[Filed Jan 9, 1998]

DECLARATION OF SPECIAL AGENT BILL NYFELER

I, BILL NYFELER, do hereby declare and say as follows:

1. I am a Special Agent with the San Francisco Field Division of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since October 1995.

2. I have received training from the DEA, Federal Bureau of Investigation, and the California Narcotics Officers Association, in specialized narcotic investigative matters including, but not limited to, the following: drug interdiction and detection, money laundering techniques and schemes, drug identification, and asset identification and forfeiture. This training included specialized training in the preparation of narcotic and

document search warrants for residences and businesses.

3. I have participated in numerous investigations specifically involving both the indoor and outdoor manufacture or cultivation of marijuana. In the course of these investigations, I have personally participated in the eradication of over 500 indoor and 5,000 outdoor marijuana plants, and the arrest of more than 50 individuals for violations of federal and state law regarding controlled substances. I also have received specialized training regarding the techniques used to grow marijuana. Based on my experience and training, I am familiar with the smell and appearance of growing and processed marijuana, as well as the smell of marijuana when it is burning. I also have participated in the obtaining and/or execution of over 50 federal and California state warrants to search a particular place or premise for controlled substances and/or related paraphernalia, indicia, and other evidence of the commission of state and/or federal felony violations of law.

4. On June 23, 1997, I made an undercover purchase of one-eighth ounce of Mexican-grown marijuana for $7 from the Oakland Cannabis Buyers' Cooperative ("OCBC"), a marijuana distribution business located in a building at 1755 Broadway Avenue, in Oakland, California. I made this undercover purchase using the OCBC membership card that had been previously issued to Special Agent Brian Nehring. The circumstances of this purchase are as follows:

5. On June 23, 1997, I was provided with Official Authorized Funds and equipped with audio and video equipment in anticipation of making an undercover

purchase of marijuana from the OCBC. I also was provided with the OCBC membership card which had previously been issued to Special Agent Nehring.

6. At approximately 2:55 p.m., I approached the entrance of 1755 Broadway Avenue, entered into a small lobby area, and flashed the OCBC membership card previously issued to Special Agent Nehring to an unidentified adult male dressed in a security guard uniform. The guard allowed me to enter, and did not ask me to provide any further identification.

7. Upon entering the elevator, I observed a sign stating that the OCBC had moved to the third floor of the building, and rode the elevator to the third floor. Upon arriving at the third floor, I walked to a desk where an unidentified adult male ("UM1") asked me to produce my membership card. I showed UM1 the OCBC membership card previously issued to Special Agent Nehring, and was allowed to enter the OCBC. I was not asked to provide any other form of identification.

8. I then proceeded to walk through the OCBC. While doing so, I observed approximately fifty marijuana plants in various stages of growth, from small clones to large flowering adult plants. Some of the plants were labeled "Educational Grow." I also observed three customers standing in line at the sales counter purchasing marijuana. Two other customers were looking at the marijuana plants, and then walked to the sales counter to purchase marijuana.

9. I then approached a sales counter, which contained several plastic bags containing green leafy

material at different prices. An unidentified adult male ("UM2") behind the counter asked me if he could help me. I responded that I wished to purchase one-eighth ounce of Mexican-grown marijuana.

10. UM2 then handed me a clear plastic bag containing a green, leafy substance, and I handed him $7 in return.

11. At approximately 3:00 p.m., I exited the OCBC, and subsequently met with a fellow Special Agent at a designated rendezvous location, whereupon I turned over the bag of suspected marijuana to this agent for evidentiary purposes.

12. The bag of suspected marijuana which I purchased from the OCBC on June 23, 1997, was subsequently marked as Exhibit 11, and transferred to the DEA Western Regional Laboratory for analysis.

13. In addition, the audio and video equipment which I utilized during my undercover purchase of marijuana from the OCBC on June 23, 1997, successfully recorded this purchase. The original tapes and recordings are currently maintained by a non-drug evidence custodian of the San Francisco Field Division of the DEA.

14. During this visit to the OCBC to make an undercover purchase of marijuana, I did not observe any other commercial activity ongoing at the OCBC except for the distribution of marijuana.

15. On September 10, 1997, I made an undercover purchase of one-eighth ounce of "AA" Mexican-grown

marijuana for $15 from the OCBC, using the OCBC membership card that had been previously been issued to Special Agent Nehring. The circumstances of this purchase are as follows:

16. On September 10, 1997, I was provided with Official Authorized Funds and the OCBC membership card previously issued to S/A Nehring, in anticipation of making an undercover purchase of marijuana from the OCBC.

17. At approximately 11:10 a.m., I approached the building at 1755 Broadway Avenue and entered into a small lobby area, where an unidentified adult male who was dressed as a security guard and seated behind a desk was playing what appeared to be a "Game Boy" handheld device. Although I had taken the OCBC membership card previously issued to Special Agent Nehring out of my pocket, I passed the security guard without showing him this card or any identification, and walked to the elevator, where a second unidentified adult male ("UM1") was also waiting for the elevator. UM1 stated that he also was going to the OCBC and, upon noticing the membership card in my hand, mentioned that I could get a new, plastic membership card with my picture on it for only $10. I thanked UM1 for the information. At this time, the security guard put down his "Game Boy," and asked me to show him my membership card. I flashed the OCBC membership card previously issued to Special Agent Nehring, and was allowed to enter the elevator.

18. Upon arriving at the third floor, I approached the front desk, showed the OCBC membership card previously issued to Special Agent Nehring, and in-

quired about obtaining a new membership card. An unidentified adult male ("UM2") seated behind the desk told me that I would have to fill out an information card. The form, when blank, asked for the customer's name, address, phone number, physician's name, illness, whether the customer had ever used marijuana before, and how the customer had used marijuana before (smoked, eaten, etc.). I completed the form using Special Agent Nehring's undercover identity. UM2 then took two pictures of me, and informed me that my new membership card would be ready in approximately 30 days. UM2 also gave me a temporary membership card, and informed me that I could use the temporary card until I had received the new membership card.

19. UM2 then asked me if I had been to the OCBC since it had moved from the fifth floor to the third floor. I responded that I had not, and UM2 gave me a brief tour of the OCBC. When we reached the marijuana sales area, which UM2 called the "Budbar," UM2 informed me that smoking and rolling marijuana cigarettes was only allowed in the "Budbar," and that when anyone left the "Budbar," all marijuana must be kept hidden in a pocket or paper bag. During this tour, I observed approximately 10 growing marijuana plants in the hallway, under a sign which read "Educational Grow."

20. I then approached the sales counter, where there were approximately 8-10 other customers standing in line waiting to purchase marijuana. While waiting, I observed a sign on the sales counter stating that the OCBC accepted Visa, Mastercard, and ATM cards. When I reached the front of the line, I asked an unidentified adult female ("UF1") behind the sales counter

for one-eighth ounce of "AA" Mexican-grown marijuana. UF1 handed me several bags containing a green, leafy substance, and informed me that, "it's really good, I've just smoked some myself."

21. I then chose one of the bags, and handed $15 to UF1.

22. At approximately 11:25 a.m., I exited the OCBC, and subsequently met with two fellow Special Agents at a designated rendezvous location, whereupon I turned over the bag of suspected marijuana to these agents for evidentiary purposes.

23. The bag of suspected marijuana which I purchased from the OCBC on September 10, 1997, was subsequently marked as Exhibit 37, and transferred to the DEA Western Regional Laboratory for analysis.

24. During this visit to the OCBC to make an undercover purchase of marijuana, I did not observe any other commercial activity ongoing at the OCBC except for the distribution of marijuana.

25. On November 14, 1997, I made an undercover purchase of one-eighth ounce of marijuana with the brand name of "House Special" for $45 from the OCBC, using the temporary OCBC membership card issued to me on September 10, 1997 in the name of Special Agent Nehring's undercover identity. The circumstances of this purchase are as follows:

26. On November 14, 1997, I was provided with Official Authorized Funds and the OCBC temporary membership card previously issued to me on Septem-

ber 10, 1997 in the name of Special Agent Nehring's undercover identity, in anticipation of making an undercover purchase of marijuana from the OCBC. I had obtained this temporary membership card from the OCBC during my previous visit to the club on September 10, 1997. On that date, I had entered the OCBC using the membership card previously originally issued to Special Agent Nehring on May 19, 1997. I never was asked to prove that I was the person named on this membership card during this visit, and was issued the temporary membership card in the name of Special Agent Nehring's undercover identity, until a permanent card with my picture was ready.

27. At approximately 2:55 p.m., I entered the front door of the building located at 1755 Broadway Avenue, and showed the OCBC temporary membership card to an unidentified adult male dressed as a security guard, and proceeded to take the elevator to the third floor. Upon arriving at the third floor, I approached the desk and produced the temporary OCBC membership card, explaining that I was there to pick up my picture membership card. The clerk informed me that the picture membership card was ready, and that the cost was $10.

28. I handed the clerk $10 in Official Authorized Funds, and the clerk handed me a white plastic identification card. The front of the card contains the OCBC logo and symbol on the left side, under which is the name of Special Agent Nehring's undercover identity, and the phony address, phone number, and other identifying information of this individual. The "issue date" was listed as 9/30/97. The right side of the card contained a picture of myself, and my signature in the name of Special Agent Nehring's undercover identity.

The back of the card contained a "Certificate of Membership" and OCBC description, with a bar code strip, and listed Jeffrey W. Jones and Matthew J. Quirk as the Co-Founders of the OCBC.

29. After I received the picture membership card, I proceeded to the "Budbar" area of the OCBC, and showed the new membership card to the guard sitting near the door. I then approached the sales counter, and observed several clear plastic baggies which contained a green, leafy material. The sales counter also contained several small bottles marked "Small Hash Oil—$30," and "Large Hash Oil—$60." I also observed a small black square substance that was labeled "Afghani Hash, 20 grams—$400." I further observed that the hydroponic marijuana grow display still contained several live marijuana plants.

30. An unidentified adult male ("UM1") approached me from behind the sales counter and asked me how he could help me. I asked for one-eighth ounce of the "House Special." UM1 stated that this would cost $45. I handed UM1 $45, and UM1 gave S/A Nyfeler a clear plastic baggie containing approximately one-eighth ounce of a green, leafy substance. I thanked UM1 and departed the "Budbar."

31. At approximately 3:05 p.m., I exited the OCBC, and subsequently met with a fellow Special Agent at a designated rendezvous location, whereupon I turned over the bag of suspected marijuana to these agents for evidentiary purposes.

32. The bag of suspected marijuana which I purchased from the OCBC on November 14, 1997, was

subsequently marked as Exhibit 55, and transferred to the DEA Western Regional Laboratory for analysis.

33. During this visit to the OCBC to make an undercover purchase of marijuana, I did not observe any other commercial activity ongoing at the OCBC except for the distribution of marijuana.

I declare under penalty of perjury that the foregoing is true and correct.

/s/ BILL NYFELER
BILL NYFELER

Executed this 8th day of January 1998

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

No. C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE,
AND JEFFREY JONES, DEFENDANTS

[Filed Jan 9, 1998]

DECLARATION OF SPECIAL AGENT CAROLYN PORRAS

I, CAROLYN PORRAS, do hereby declare and say as follows:

1. I am a Special Agent with the San Francisco Field Division of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since August 1996.

2. I have received training from the DEA and Federal Bureau of Investigation in specialized narcotic investigative matters including, but not limited to, the following: drug interdiction and detection, money laundering techniques and schemes, drug identification, and asset identification and forfeiture. This training included specialized training in the preparation of nar-

cotic and document search warrants for residences and businesses.

3. I have participated in numerous investigations specifically involving both the indoor and outdoor manufacture or cultivation of marijuana. In the course of these investigations, I have personally examined approximately 15 indoor and outdoor marijuana plants. I also have participated in the arrest of more than 30 individuals for violations of federal and state law regarding controlled substances. I also have received specialized training regarding the techniques used to grow marijuana. Based on my experience and training, I am familiar with the smell and appearance of growing and processed marijuana, as well as the smell of marijuana when it is burning. I also have participated in the obtaining and/or execution of five federal and California state warrants to search a particular place or premises for controlled substances and/or related paraphernalia, indicia, and other evidence of the commission of state and/or federal felony violations of law.

4. On August 8, 1997, I made an undercover purchase of one-eighth ounce of marijuana for $25 from the Oakland Cannabis Buyers' Cooperative ("OCBC"), a marijuana distribution business located in a building at 1755 Broadway Avenue, in Oakland, California. I made this undercover purchase using the OCBC membership card that had been previously been issued to Special Agent Brian Nehring. The circumstances of this purchase are as follows:

5. On August 8, 1997, I was provided with Official Authorized Funds and the OCBC membership card previously issued to Special Agent Nehring, in antici-

pation of making an undercover purchase of marijuana from OCBC.

6. At approximately 2:57 p.m., I approached the building at 1755 Broadway Avenue, and walked into the building and entered into a lobby area, where an unidentified adult male dressed as a security guard inquired where I was going. In response, I flashed the membership card previously issued to Special Agent Nehring, and continued to walk toward the elevator. As I hit the elevator button, I noticed a sign advising that the OCBC had moved from the fifth floor to the third floor.

7. Upon arriving at the third floor, I approached a room containing a desk, file cabinets, sofas, and a door leading to entrances to other rooms. I then was approached by an unidentified adult female ("UF1"), who asked me if I was there to make a purchase. I responded that I was. UF1 then asked me for my memberhip card, and I gave her the OCBC membership card previously issued to Special Agent Nehring. UF1 then yelled out the membership number to an unidentified adult male ("UM1") seated in the same room. A few seconds later, UM1 informed UF1 that the membership number which she had called out was closed.

8. I asked UF1 why the membership number was closed. UF1 stated that a possibility could be that the file doesn't have a physician letter but that she (UF1) would check. I then observed UF1 hand over the membership card to a second unidentified adult male ("UM2"), who walked over to a room where there were at least two computers inside. A few seconds later, UM2, after appearing to work on one computer for a

moment, returned and instructed UF1 to reopen the file.

9. UF1 then asked S/A Porras whether the person named on the membership card (Special Agent Nehring's undercover identity) had called to notify the OCBC that a third party would be making a purchase for him. I responded that I thought that this person had called, but that this person was very sick, and thus I could not be sure whether he in fact had called. UF1 explained to me that, as an alternative, I needed to have a letter from this person authorizing me to make purchases for him. I responded that I would do that the next time, but asked to be allowed to make a purchase on that day. UF1 stated that I would be allowed to make a purchase for that day only.

10. I then was instructed to go out into another room at the end of the hallway. When I asked for directions, I was told to "follow my nose." I proceeded to walk down and enter a large room at the end of the hallway, where the smell of burning marijuana was readily apparent. In this room, I observed at least fifteen marijuana plants being grown, with lights, fans, and timer clocks pointed directly at the plants.

11. I then proceeded to walk towards the glass sales counter which contained several clear plastic baggies containing green, leafy material. Approximately 4-5 other customers were standing in line in front of me. When I reached the front of the line, a second unidentified adult female ("UF2") asked me what I wanted to purchase. I pointed to a clear plastic baggie labeled "Mexican AA-Grade A," for $25 for one-eighth ounce.

12. I then purchased one-eighth ounce of the OCBC identified as Mexican-grown marijuana for $25.

13. As I turned to leave the OCBC, I observed approximately 5-10 individuals standing in line behind me, apparently to purchase marijuana from the OCBC.

14. At approximately 3:10 p.m., I exited the OCBC, and subsequently met with two fellow Special Agents at a designated rendezvous location, whereupon I turned over the bag of suspected marijuana to these agents for evidentiary purposes.

15. The bag of suspected marijuana which I purchased from the OCBC on August 5, 1997, was subsequently marked as Exhibit 33, and was transferred to the DEA Western Regional Laboratory for analysis.

16. During this visit to the OCBC to make an undercover purchase of marijuana, I did not observe any other commercial activity ongoing at the OCBC except for the distribution of marijuana.

17. On October 22, 1997, I received a message on the DEA undercover line from a "Nurse Laura Lee," who wanted to confirm that the "doctor" had signed the physician statement used by Special Agent Deborah Muusers, acting in an undercover capacity, to make an undercover purchase of marijuana from the OCBC. Thereafter, at approximately 3:40 p.m., acting in an undercover capacity, I answered a call made to the same undercover telephone line. An individual who identified himself as "Shawn," and who claimed to be calling from the OCBC, inquired whether the address listed on the phony physician statement used by Special

Agent Muusers had a suite number or floor, or whether the address was a house. I told "Shawn" that the address was the first floor. "Shawn" then stated that the OCBC wanted to send a representative to the office to meet with the doctor. I responded that I was walking out the door. "Shawn" inquired what time the doctor would be in the following day, to which I responded that the doctor would be in after 10:00 a.m.

19. Later on October 22, 1997, at approximately 4:25 p.m., acting in an undercover capacity, I called "Shawn" at 510-832-5346, and informed him that I was a new doctor to the Bay Area and didn't want involvement with the OCBC if persons from the club were planning on visiting me. I further informed "Shawn" that I was requesting that the OCBC cancel this patient's membership. "Shawn" responded, "We already did."

I declare under penalty of perjury that the foregoing is true and correct.

/s/ CAROLYN PORRAS
CAROLYN PORRAS

Executed this 8th day of January 1998

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

No. C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE,
AND JEFFREY JONES, DEFENDANTS

[Filed Jan 9, 1998]

DECLARATION OF SPECIAL AGENT
DEBORAH MUUSERS

I, DEBORAH MUUSERS, do hereby declare and say as follows:

1. I am a Special Agent with the San Francisco Field Division of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since July 1991.

2. I have received training from the DEA in specialized narcotic investigative matters including, but not limited to, the following: drug interdiction and detection, money laundering techniques and schemes, drug identification, and asset identification and forfeiture. This training included specialized training in the

preparation of narcotic and document search warrants for residences and businesses.

3. I have participated in numerous investigations specifically involving both the indoor and outdoor manufacture or cultivation of marijuana. In the course of these investigations, I have personally examined approximately 250 indoor and outdoor marijuana plants. I also have participated in the arrest of more than 100 individuals for violations of federal and state law regarding controlled substances. I also have received specialized training regarding the techniques used to grow marijuana. Based on my experience and training, I am familiar with the smell and appearance of growing and processed marijuana, as well as the smell of marijuana when it is burning. I also have participated in the obtaining and/or execution of more than 100 federal and California state warrants to search a particular place or premises for controlled substances and/or related paraphernalia, indicia, and other evidence of the commission of state and/or federal violations of law.

4. On October 22, 1997, I made an undercover purchase of one-eighth ounce of marijuana with the brand name of "That's Purdy" for $60 from the Oakland Cannabis Buyers' Cooperative ("OCBC"), a marijuana distribution business located at 1755 Broadway Avenue, in Oakland, California. I made this undercover purchase using an undercover name, identification, and a phony physician statement. The circumstances of this purchase are as follows:

5. On October 24, 1997, I was provided with Official Authorized Funds and a phony physician statement, in anticipation of making an undercover purchase of mari-

juana from the Marin Alliance. The phony physician statement used by my undercover identity as the patient's name, and stated that this person suffered from "Menstrual Cramps." The marijuana distribution center designated was the "Oakland C.B.C." The doctor listed on the statement also was a phony identity. A telephone number for the doctor listed on the statement was for an undercover telephone line to the DEA San Francisco. I also was provided with a concealed video and audio recording device with microphone.

6. At approximately 11:05 a.m., I entered the building at 1755 Broadway Avenue, and was stopped by an unidentified adult male wearing a security guard's uniform, who asked me what was my business. I told the guard that I wanted to establish membership, to which the guard responded that I needed a piece of paper from a doctor. I informed the guard that I had a document from a doctor, whereupon the guard asked to see the document and my driver's license. I produced the phony physician statement and my undercover identification, and was directed up the stairs to a reception area, as the elevator was inoperable. As I passed him, the guard announced on a hand-held radio that I was on my way up to "intake."

7. I walked upstairs and along a corridor into a reception area, where I came upon an adult male sitting behind a desk, upon which there was a nameplate with the name "Shawn." I informed "Shawn" that I wished to establish membership at the OCBC, and produced the phony physician statement and my undercover identification. "Shawn" gave me several forms to fill out, including a registration form asking for a bio-

graphical data, such as the ailment for which the customer wished to purchase marijuana, and a medical release form that would allow the OCBC to call a patient's doctor to divulge patient information. I filled out these forms, and listed "menstrual cramps" as my medical ailment. "Shawn" photocopied my phony physician statement and undercover identification, and returned both originals to me.

8. "Shawn" then gave me a temporary membership card. The front of the card contains the OCBC symbol on the left, the OCBC's name on the right, and blank listings for the customer's membership number and name. The customer's name was filled in with my undercover identity. At the top of the card, the words, "Exp. 11/22/97 *Need photo taken," were written in. The back of the card lists the OCBC's hours as 11:00 a.m. to 7:00 p.m. on Monday and Friday, and 11:00 a.m. to 1:00 p.m., and 5:00 p.m. to 7:00 p.m., from Tuesday through Thursday, and contains blank listings for the customer's name, address, and phone number. None of these listings were filled in. The membership card did not contain picture identification.

9. "Shawn" then informed me that, during the next visit to the OCBC, a photo would be taken in-house, after the club's camera had been set up, and a undetermined fee would be charged. "Shawn" then directed me to the "bar," which was back along the corridor. During this period, I observed three other individuals enter the reception area to speak with "Shawn."

10. I then walked down the corridor and came upon a second adult male dressed in a guard's uniform, stationed at a desk at the entrance to the "bar." I showed

the guard my temporary membership card and was allowed into the "bar." The "bar" area consisted of a large room with several couches in a sitting area, and several glass counters with various items enclosed within. Inside one of the glass cases were approximately 20-25 6"-8" inch marijuana plants growing inside. Against one wall of the "bar" area was a cubicle with grow lights and approximately 5-6 larger plants, approximately 3'-3 1/2' tall. One glass counter contained various food items that purported to contain marijuana, including brownies and rice krispie treats. Another glass counter contained drug paraphernalia, including pipes. A third glass counter contained samples of what was purported to be marijuana, ranging in quantity from 1 gram to one-eighth ounce. For the one-eighth ounce quantity, the prices ranged from $15 to $60. I observed approximately 3-4 individuals sitting on the couches, and there were approximately 5-6 other customers waiting in line to purchase marijuana. The smell of burning marijuana was readily apparent.

11. When I reached the front of the line, I spoke to an unidentified adult male ("UM1") behind the counter, and asked to purchase one-eighth ounce of marijuana with the "brand name" of "That's Purdy." UM1 proceeded to take two ziploc baggies, each containing what appeared to be marijuana, from a container, and placed the baggies on the counter. I chose one of the baggies, and gave UM1 $60 in return. UM1 placed the $60 in a cash register.

12. At approximately 11:30 a.m., I exited the OCBC, and subsequently met with two fellow Special Agents at a designated rendezvous location, whereupon I

turned over the bag of suspected marijuana to these agents for evidentiary purposes.

13. The bag of suspected marijuana which I purchased from the OCBC on October 22, 1997, was subsequently marked as Exhibit 41, and was transferred to the DEA Western Regional Laboratory for analysis.

15. In addition, the audio and video equipment which I utilized during my undercover purchase of marijuana from the OCBC on October 22, 1997, successfully recorded this purchase. The original tapes and recordings are currently maintained by a non-drug evidence custodian of the San Francisco Field Division of the DEA.

16. During this visit to the OCBC to establish membership, I did not observe any other commercial activity ongoing at the OCBC except for the distribution of marijuana.

I declare under penalty of perjury that the foregoing is true and correct.

/s/ DEBORAH MUUSERS
DEBORAH MUUSERS

Executed this 8th day of January 1998

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE, AND
JEFFREY JONES, DEFENDANTS

[Filed: Jan. 9, 1998]

DECLARATION OF PHYLLIS E. QUINN

I, PHYLLIS E. QUINN, do hereby declare and say as follows:

1. I am a Senior Forensic Chemist with the Western Laboratory of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since November 1983.

2. My principal duty with the DEA Western Laboratory is the analysis of controlled substances. Prior to my current position, I served as a Forensic Chemist with the NIS Regional Laboratory in Pearl Harbor, Hawaii, from September 1981 to November 1983, and as a Forensic Chemist with the Bureau of

Forensic Sciences in Richmond, Virginia, from October 1978 to August 1981. My principal duty in both positions was the analysis of controlled substances.

3. I received a Bachelor of Science in Chemistry from Mary Washington College, in Fredericksburg, Virginia, in 1977, and a Master of Science in Forensic Chemistry from the University of Pittsburgh, in Pittsburgh, Pennsylvania, in 1978. Since 1979, I have taken numerous additional courses and seminars on various issues involving forensic chemistry, including several specifically related to the analysis of controlled substances. Among others, these courses and seminars were sponsored by the DEA; American Chemical Society; McCrone Institute; Bowdoin College; and United States Environmental Protection Agency. I also have published articles related to the analysis of methamphetamine and phencyclidine ("PCP") in *Microgram* and the *Journal of Analytical Toxicology*. I am a member of the Mid-Atlantic Association of Forensic Scientists and the Clandestine Laboratory Investigative Chemists Association.

4. On May 22, 1997, I conducted an analysis of 3.2 grams of a green, leafy substance contained in two clear plastic bags which had been marked as Exhibit 11. My analysis of the substances contained in the bags marked as Exhibit 11 identified the presence of marijuana.

5. On July 3, 1997, I conducted an analysis of 3.4 grams of a green, leafy substance contained in a clear plastic bag which had been marked as Exhibit 23. My analysis of the substance contained in the bag marked as Exhibit 23 identified the presence of marijuana.

6. On August 13, 1997, I conducted an analysis of 3.4 grams of a green, leafy substance contained in a clear plastic bag which had been marked as Exhibit 33. My analysis of the substance contained in the bag marked as Exhibit 33 identified the presence of marijuana.

7. On September 15, 1997, I conducted an analysis of 3.4 grams of a green, leafy substance contained in a clear plastic bag which had been marked as Exhibit 37. My analysis of the substance contained in the bag marked as Exhibit 37 identified the presence of marijuana.

8. On October 28, 1997, I conducted an analysis of 3.3 grams of a green, leafy substance contained inside a clear plastic bag which had been marked as Exhibit 41. My analysis of the substance contained in the bag marked as Exhibit 41 identified the presence of marijuana.

9. On November 21, 1997, I conducted an analysis of 3.3 grams of a green, leafy substance contained inside a clear plastic bag which was marked as Exhibit 55. My analysis of the substance contained in the bag marked as Exhibit 55 identified the presence of marijuana.

I declare under penalty of perjury that the foregoing is true and correct.

/s/ PHYLLIS E. QUINN
PHYLLIS E. QUINN

Executed this 23 day of December 1997

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO HEADQUARTERS

C 98-0088-CAL

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE; AND
JEFFREY JONES, DEFENDANTS

[Filed: Jan. 9, 1998]

DECLARATION OF SPECIAL AGENT MARK NELSON

I, MARK NELSON, do hereby declare and say as follows:

1. I am a Special Agent with the San Francisco Field Division of the Drug Enforcement Administration ("DEA"), United States Department of Justice, and have been so employed since December 1985.

2. I have received training from the DEA and Federal Bureau of Investigation in specialized narcotic investigative matters including, but not limited to, the following: drug interdiction and detection, money laundering techniques and schemes, drug identification, and asset identification and forfeiture. This training included specialized training in the preparation of

narcotic and document search warrants for residences and businesses.

3. I have participated in numerous investigations specifically involving both the indoor and outdoor manufacture or cultivation of marijuana. In the course of these investigations, I have personally participated in the eradication of over 12,000 indoor and 5,000 outdoor marijuana plants, and the arrest of more than 200 individuals for violations of federal and state law regarding controlled substances. I also have received specialized training regarding the techniques used to grow marijuana. Based on my experience and training, I am familiar with the smell and appearance of growing and processed marijuana, as well as the smell of marijuana when it is burning. I also have participated in the obtaining and/or execution of over 150 federal and California state warrants to search a particular place or premises for controlled substances and/or related paraphernalia, indicia, and other evidence of the commission of state and/or federal felony violations of law.

4. On May 20, 1997, acting in an undercover capacity, I telephoned the Oakland Cannabis Buyer's Cooperative ("OCBC") at 510-832-5346 and spoke to an individual whom I assumed was an employee of the OCBC. I informed this individual that I had been contacted by a patient of the doctor who had been listed on Special Agent Brian Nehring's phony physician statement, who told me that the OCBC may be calling to verify that he (Special Agent Nehring, acting in an undercover capacity) was a patient of the doctor. I told this individual that I was affirming that this individual (Special Agent Nehring, acting in an undercover

capacity) was a patient of this doctor, and that this doctor had signed a physician statement to that effect.

I declare under penalty of perjury that the foregoing is true and correct.

/s/ MARK NELSON
MARK NELSON

Executed this 8th day of January 1998

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00089 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OF ROBERT T. BONARDI

I, ROBERT T. BONARDI, declare:

1. I am a patient-member of the Oakland Cannabis Buyers' Cooperative ("OCBC"). I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I live in Hayward, California with my wife of 53 years. I am the father of three children, and I have four grandchildren. I have owned a vacuum cleaner store for the past 20 years. I am no longer able to go to my store to work because I have cancer and am undergoing chemotherapy.

3. I was first diagnosed with cancer of the throat ten years ago. I underwent radiation therapy as part of my treatment then. At that time the doctors removed my voicebox and performed a tracheotomy. I still have a hole in my throat.

4. Two years ago I lived through prostate cancer.

5. Earlier this year the doctors discovered a tumor on the side of my neck. They removed it, but later the doctors discovered more tumors on my shoulder, chest, and neck area. Since I have already had radiation treatments, I had to undergo intensive chemotherapy for these new cancers.

6. After they started the chemotherapy treatments this year, I got really sick. The nausea was so bad I would retch whenever I thought about food or whenever anyone tried to put food in front of me. The nausea made me particularly afraid to eat because my throat condition makes it especially unpleasant if I vomit. Not only would vomit come out of my mouth, but it would also come out of my nose.

7. Over a period of about six weeks, I lost forty pounds. My wife and children became very worried about my not eating and about my dramatic weight loss.

8. I tried some medicines the doctors prescribed for me to help me with the nausea and my lack of appetite, but none of them worked for me. I took them but still I could not bring myself to eat. I was still losing weight.

9. Eventually, my daughter Judy forced me to go with her to the Oakland Cannabis Buyers Cooperative.

At first I did not want to go. It took my daughter a long time to convince me to go. I am 74 years old and I had never used marijuana before in my life.

10. The OCBC gave me papers to take to my doctor to fill out. My E.N.T. doctor from Kaiser in Fremont signed the papers. My daughter took me back to the OCBC. I bought cannabis brownies, some cannabis pills, and some cannabis banana muffins. Because of my condition I cannot smoke.

11. The first day I ate half a cannabis brownie before breakfast and nothing much happened.

12. Later that same day, I ate another half brownie and for the first time in several weeks, I felt like eating. The brownie caused my nausea to go away. I asked my wife to cook me eggs and sausage. She was so happy because it had been so long since I had asked for food. I have since regained some of the weight I lost.

13. Cannabis is the best medicine for my conditions caused by the chemotherapy treatments. In fact, it is the only medicine that has worked for me. I believe that without cannabis I would have continued to starve.

14. The OCBC has provided a safe place where I can get this life-saving medicine. If cannabis were not available through OCBC, I would be forced to go without the only medicine that has worked for me to relieve my nausea and to give me my appetite back. I would refuse to get my medicine from criminal street dealers.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 9/10/98 day of September at Oakland, California.

/s/ ROBERT J. BONARDI
ROBERT J. BONARDI

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Nos. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98-00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION

TO THIS HONORABLE COURT:

1. My name is Willie C. Beal. I am over 18 years of age and am of sound mind. I make the following statements upon my own personal knowledge of the facts stated herein. If called upon, I am willing to testify orally to such matters.

2. The Oakland Cannabis Buyers' Cooperative helps me in the following ways: Its helps me to eat. I need to eat so that I can gain weight. If I don't eat I die. Food makes me want to throw-up that's what cancer does to you. And the pain you are in, unbearable pain. It really helps! The club has kept me alive from day to day.

3. If the Oakland Cannabis Buyers' Cooperative were to close, I would suffer imminent serious harm in the following ways: I would die, I would simply die. You lose wieght [*sic*] fast with cancer. You can't eat, everything makes you sick, I'm alergic [*sic*] to everything so I have to have something everyday. I'm too old and in too much pain to try to go on the street. I live in Oakland and it is hard, very hard. I'm trying to live from day to day this is helping me to make it. Please don't take this away. It would kill me, my birthday is October 31. I will be 71 years old. If I live to make it. Please don't murder innocent victims of the club! Have some compassion! You may be in my shoes one day.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

WILLIE BEAL
Signature

WILLIE C. BEAL
Print Name

Declared and signed in Oakland, California this 15th day of October, 1998. This order is signing my death warrant as if I was a person on death row in prison who is innocent.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00089 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OF ALBERT DUNHAM

I, ALBERT DUNHAM, declare:

1. My name is Albert Dunham. I am 43 years of age, am of sound mind, and am competent to testify to the matters stated herein.

2. I am a member of the Oakland Cannabis Buyers' Cooperative. I was present at the Cooperative on May 21, 1998.

3. I was diagnosed as HIV-positive in June, 1996. As a result of my disease, I have suffered from constant nausea, fatigue, insomnia, lack of appetite, weight loss, and pain throughout my back, neck, and head. Due to these problems, I was unable to maintain my job as a

warehouse shipping and receiving clerk and am currently unemployed.

4. I have tried medicine other than cannabis to combat these problems, but they always had adverse side effects on my body, primarily by inducing vomiting. My stomach is very sensitive and does not react well to ingesting pills. At the end of 1997, my doctor prescribed cannabis for my symptoms, especially to alleviate my steady weight loss. My appetite had deteriorated so badly by this point that there were occasions when I had only one meal every two days.

5. I have been using medicinal cannabis for the past ten months, and the improvement in my overall health has been dramatic. My appetite has returned, along with some of the weight I lost, leading me to believe that continued use would allow me to return to my normal weight. In addition to my increased appetite, regular use of cannabis has alleviated the pain I feel throughout my body and generally relaxed me by reducing the anxiety and stress associated with my disease and symptoms. My insomnia has also improved.

6. Unlike other drugs I have tried for my illness, cannabis has left no lingering side effects. Using cannabis allows me to live a normal life, something I was unable to achieve prior to my doctor's prescription.

7. I live with my daughter, 27, who is supportive of my use of cannabis to fight the medical problems I have described. I have a new doctor now, and he is also supportive of my continued use of cannabis to combat my weight loss and other symptoms.

8. If I was no longer able to obtain cannabis through the OCBC, I would be forced to the streets to obtain it, which is a situation that I am emotionally and financially unprepared for. I have doubts that I would be able to obtain cannabis under those conditions. The OCBC's continued existence insures that I will have a safe, clean location that I can regularly visit to obtain the medicine I require.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 13 day of September, in Oakland, California.

/s/ ALBERT DUNHAM
ALBERT DUNHAM

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00088 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE, ET AL.,
DEFENDANTS

DECLARATION OF TERRY STOGDELL

TO THIS HONORABLE COURT:

1. My name is Terry Stogdell. I am over 18 years of age and am of sound mind. I make the following statements upon my own personal knowledge of the facts stated herein. If called upon, I am willing to testify orally to such matters.

2. I suffer from the following serious medical conditions: I have severe AIDS, hemophilia, arthritis, and asthma.

3. If I did not have access to cannabis, I would suffer imminent harm in the following ways: I would not be able to eat and would waste away. The medications I take for AIDS take away my appetite and make me nauseous. When my stomach is upset I don't eat, and I might not take the medications that are vital to my treatment. Cannabis eases my pain, makes the nausea go away, and stimulates my appetite. As an appetite

stimulant, it works consistently and quickly. Cannabis relaxes my upset stomach, helps me eat, and lets me take my vital medications. Cannabis also helps relieve severe pain in my joints.

4. There is no alternative to cannabis for the effective treatment of my medical condition, because I have tried the following legal alternatives to cannabis and have found them to be ineffective, or to result in intolerable side effects: I have taken Marinol and Megace to stimulate my appetite and fight AIDS related wasting. Marinol is inconsistent in stimulating my appetite, and Megace is not effective at all. Both drugs can make me nauseous. I have taken Compazine for nausea. However, it causes painful cramps in my fingers and toes. I am currently taking Dilauded, a very strong pain medication that can cause bleeding in my joints. With cannabis, I can ease my pain while considerably reducing the amount of Dilauded that I would otherwise have to take.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge and belief.

/s/ TERRY STOGDELL
TERRY STOGDELL

Declared and signed in Oakland, California this 27th day of April, 2000.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00088 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

OAKLAND CANNABIS BUYERS' COOPERATIVE, ET AL., DEFENDANTS

DECLARATION OF CREIGHTON W. FROST, JR.

TO THIS HONORABLE COURT:

1. My name is Creighton W. Frost Jr. I am over 18 years of age and am of sound mind. I make the following statements upon my own personal knowledge of the facts stated herein. If called upon, I am willing to testify orally to such matters.

2. I suffer from the following serious medical conditions: I am a cancer survivor. I am post-operative for throat and shoulder cancer. I have resultant muscle loss, and I use a voice prosthesis. I also suffer from severe depression as a result of my medical condition.

3. If I did not have access to cannabis, I would suffer imminent harm in the following ways: I would suffer chronic and intense pain on the right side of my neck and chest, where I had surgery. If high quality medical cannabis were available at an affordable price, I would not need any other pain medications. Without access to cannabis, I would suffer from the constant and extreme

nausea that results from the cancer medications that I take. Medical cannabis relieves this nausea.

4. There is no alternative to cannabis for the effective treatment of my medical condition, because I have tried the following legal alternatives to cannabis and have found them to be ineffective, or to result in intolerable side effects: I currently take Oxycontin, a morphine derivative and Ultram, a synthetic narcotic for pain relief. I find both make me groggy and sleepy, and both harm my mental clarity. Both can cause constipation. I take Oxycontin and Ultram in conjunction with cannabis. When more high quality cannabis is available, I need to take less Oxycontin and Ultram. I have tried Prozac and Zoloft for fighting depression. Both of these drugs cause me to lose normal inhibitions and can make me act in dangerously inappropriate ways. Cannabis relieves my depression without side effects. I have taken Marinol to relieve the nausea that I suffer, but I find it to be ineffective.

5. Being unable to obtain medical cannabis from the Oakland Cannabis Buyers' Cooperative has effected my health and well-being in the following ways: It has resulted in my suffering from poor health overall, extreme depression, more pain, and bouts of anger.

I declare under penalty of perjury under the laws of the State of California that the forgoing is true and correct to the best of my knowledge and belief.

/s/ CREIGHTON W. FROST JR.
CREIGHTON W. FROST JR.

Declared and signed in Oakland, California this 29th day of April, 2000.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00089 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OF HAROLD SWEET

I, HAROLD SWEET, declare:

1. I am a patient-member of the Oakland Cannabis Buyers' Cooperative (the "Cooperative"). I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I am a retired school teacher. I taught botany and biology in a junior college. I am sixty-four years old. I suffer from glaucoma.

3. I was first diagnosed with glaucoma in 1994. At that time my field of vision was deteriorating rapidly. Also, I experienced intense pain from the build up of

pressure in my eyes. I also experienced pain when I was exposed to bright lights. I often had to go lie down in a dark room just to try to escape the pain.

4. Prior to my eye disease, I was never an illicit drug user or somebody who used marijuana. Personally, I have actually always been opposed to the so-called "pot-heads" in our society.

5. Since my glaucoma diagnosis I have been taking medical cannabis for my condition. This medicine has worked wonders. First, the medical cannabis keeps my eye pressure down. When I medicate with cannabis, the pain goes away, and I no longer experience intense pain from bright lights.

6. Second, much to my doctor's amazement, not only has my field of vision not deteriorated any further since I have been medicating with cannabis, but it may have even improved. Also, my doctor has told me that my optic nerve is in good shape. I attribute this to the cannabis treatment.

7. There is a very strong possibility that I would be blind if I did not take cannabis for my glaucoma.

8. Though I have tried other drugs and treatments for my glaucoma, no other drug or treatment works for me.

9. According to my doctor's suggestion, I have been modulating my use of medical cannabis. Currently, I smoke a little bit of cannabis three times a day. This is the only way I know how to get through the day without pain. It is also the only way I know how to maintain my vision.

10. The Cooperative has provided a safe place where I can get this life-saving medicine. If cannabis were not available through the Cooperative, I would be forced to go without the only medication that has worked to alleviate my glaucoma.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 10 day of September at Oakland, California.

/s/ HAROLD SWEET
HAROLD SWEET

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Case No. C 97-0139 FMS

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED; BAY AREA PHYSICIANS FOR HUMAN RIGHTS; AND BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., PLAINTIFFS

v.

BARRY R. MCCAFFREY, AS DIRECTOR, UNITED STATES OFFICE OF NATIONAL DRUG CONTROL POLICY; THOMAS A. CONSTANTINE, AS ADMINISTRATOR, UNITED STATES DRUG ENFORCEMENT ADMINISTRATION; JANET RENO, AS ATTORNEY GENERAL OF THE UNITED STATES; AND DONNA SHALALA, AS SECRETARY OF HEALTH AND HUMAN SERVCIES, DEFENDANTS

March 21, 1997
[Original Filed: Feb. 14, 1997]

DECLARATION OF MARCUS A. CONANT, M.D.

I, Dr. Marcus A. Conant, declare as follows:

1. I am a physician licensed to practice in the State of California and a clinical professor of dermatology at the University of California Medical Center in San

Francisco ["UCSF"], where I have taught for more than 30 years. I am also Medical Director of the largest private HIV/AIDS practice in the San Francisco Bay Area. Since establishing that practice, my colleagues and I have treated some 5,000 HIV-infected men and women, and we currently provide care for approximately 3,000 AIDS patients in both our clinic and our research facility.

2. I received a bachelor's degree in 1957 and a doctorate in 1961, both from Duke University. I subsequently completed an internship in internal medicine at the Duke University Medical Center (1961-1962), and a residency in dermatology at UCSF in San Francisco (1964-1967). I received further training at the School of Aerospace Medicine in San Antonio, Texas, and served in the United States Air Force from 1962 to 1964, as both a Medical Officer and a Flight Surgeon. I continued to serve as an Air Force Reserve Officer until 1967.

3. Since joining the UCSF faculty as a Clinical Instructor in 1967, I have held numerous positions, including Assistant Clinical Professor, Associate Clinical Professor, and Clinical Professor of Dermatology, a post I have held since 1984. I was Chief of both the Dermatology Clinic and the Dermatology Inpatient Service from 1967 through 1970, Co-Director of the Medical Center's Kaposi's Sarcoma Clinic (1981-1985), and Director of its AIDS Clinical Research Center (1983-1985). I am currently an Adjunct Professor at its Mount Zion Medical Center as well.

4. Throughout my career, I have also been a consultant to numerous agencies and service providers, both public and private, including San Francisco Gen-

eral Hospital, the U.S. Public Health Service Hospital, UC Medical Center's Director of Hospitals and Clinics, and the California State Assembly Ways and Means Committee's AIDS Task Force. I have been appointed to similar task forces and committees of the Fifth Congressional District, the California State Department of Health Services, the California Medical Association, the San Francisco Medical Society, the American Academy of Dermatology, and the City of San Francisco. In 1983, I represented the United States at the World Health Organization meeting on AIDS. I served as Medical Director of the National Public Health Project Against AIDS for several years. I am currently a member of United States Senator Dianne Feinstein's AIDS Committee.

5. I have authored and co-authored some 70 articles in scholarly and professional journals, most of which deal with the diagnosis and treatment of AIDS and AIDS-related conditions. My work has been published in the Journal of the American Medical Association, New England Journal of Medicine, Western Journal of Medicine, Journal of the American Academy of Dermatology, Journal of Infectious Disease, American Journal of Clinical Pathology, Journal of Clinical Immunology, Journal of Osteopathic Medicine, American Journal of Oral Medicine, Public Health Reports, Clinical Research, American Journal of Pathology, and The Lancet. My colleagues and I have contributed chapters to medical textbooks, research publications, clinical protocols and conference reports. I am a frequent presenter at national and international conferences and congresses.

6. Many of the therapies used in the treatment of AIDS-related conditions can cause symptoms and medical complications which themselves are physically painful and medically dangerous. The most frequently cited example is chemotherapy, which is often a first-line treatment in the aggressive treatment of cancer. Chemotherapy has also been used in the treatment of several common AIDS-related conditions, including lymphoma and Kaposi's sarcoma. Chemotherapy—administering medications such as adriamycin, fluorouracil, cytotoxin and methotrexate, usually in combination—has proven to be highly effective in the treatment of many cancers, extending lives and relieving the symptoms of many individuals whose conditions were once considered hopeless. These medications have been approved by the FDA. Nonetheless, chemotherapy protocols used in the treatment of cancer often cause nausea and retching which is sometimes thoroughly disabling. They can result in severe weight loss, which itself has troubling implications not only for the efficacy of the treatment, but for a patient's health generally. The medications are indeed toxic. Administration of these drugs always includes considering potential adverse effects, advising the patient of the risks and providing information and treatment to reduce harmful or undesirable side effects. Acknowledgment and clinical treatment of those effects are standard and necessary parts of the chemotherapy protocols.

7. Other drugs frequently prescribed in the treatment of AIDS-related conditions have the potential to cause adverse medical conditions. Among them are AZT, ddI, ddC and d4T, all of which are approved by the FDA. More recently, physicians have prescribed a

class of drugs known as "protease inhibitors," often in combination with other medications. The results have been very promising. Physicians are seeing positive clinical results, and laboratory findings (blood tests) show remarkable improvements. Many patients report great relief from physical suffering. These drugs are now approved by the FDA. One common AIDS-related condition is wasting syndrome, which undermines both the immune system generally and a patient's ability to withstand the effects of other therapies. The FDA has approved the use of Somatropin (human growth syndrome), as well as Megace and Marinol, to reverse the disabling effects of wasting syndrome.

8. As with all medications, further research is essential to our understanding of these medications. As research continues, the use of these medications (*e.g.*, dosages, means of ingestion, combination therapies) will be refined to maximize the potential for treatment and minimize adverse reactions. That is the very nature of research. There are always risks. As scientists, we identify those risks and provide information to reduce and ultimately eliminate those risks. As healers, we advise our patients accordingly and work with them to address their individual medical needs. Caution and candor are essential to maintaining scientific integrity and providing effective treatment.

9. Medical marijuana has been used extensively by physicians throughout the United States in the treatment of cancer and AIDS patients. It stimulates the appetite and promotes weight gain, in turn strengthening the body, combating chronic fatigue, and providing the stamina and physical well-being necessary to endure or withstand both adverse side effects of

ongoing treatment and other opportunistic infections. It has been shown effective in reducing nausea, neurological pain and anxiety, and in stimulating appetite. When these symptoms are associated with (or caused by) other therapies, marijuana has been useful in facilitating compliance with more traditional therapies. It may also allow individual patients to engage in normal social interactions and avoid the despair and isolation which frequently accompanies long-term discomfort and illness. In glaucoma patients, marijuana has been effective in decreasing inter-ocular pressure. The evidence behind these findings is both scientific and anecdotal. The research in this area has been documented and published in the leading scientific journals, including the New England Journal of Medicine and Annals of Internal Medicine.

10. In my practice, marijuana has been of greatest benefit to patients with wasting syndrome. I do not routinely recommend marijuana to my patients, nor do I consider it the first line of defense against AIDS-related symptoms. However, for some patients, marijuana proves to be the only effective medicine for stimulating appetite and suppressing nausea, thus allowing the AIDS patient to recover lost body mass and become healthier. Likewise, for some of my patients undergoing chemotherapy, when conventional drugs fail to relieve the severe nausea and vomiting, I often find that marijuana provides the patient with the ability to eat and to tolerate aggressive cancer treatments. As with any medication, I am aware of the potential for abuse and I am cautious in the information I provide. Some of my patients are using marijuana, which I learn in the course of my treatment. I advise those patients of the risks that marijuana may pose. In

some instances, I have counseled patients to discontinue or decrease their use of marijuana. In patients with a history of substance abuse, I am especially vigilant in recommending caution. Physicians have always been held to that standard, whether the medication is Valium, morphine, Xanax, or marijuana. Safeguards to decrease the incidence and effects of substance abuse are already in effect. Medical practices in prescribing and recommending all treatments are monitored and subject to professional and legal guidelines.

11. It is the sanctity of the doctor-patient relationship that enables this counseling and guidance to take place. The unique nature of that relationship has been recognized throughout history. Legally, ethically and clinically, a physician has unique duties to a patient in his or her care. When I treat a patient with a potentially terminal condition, I provide the information and treatment that can literally determine whether my patient lives or dies. My duty is to provide accurate and complete information and treat each patient according to his or her individual symptoms, medical history and clinical responses. Each patient's medical needs are unique, as are his/her responses to specific therapies. Confidential communication is essential to this process.

12. As a physician responsible for the care and well-being of my patients, I cannot ignore information which might affect my assessment of a patient's condition or assist me in providing the best care possible. If I have knowledge that a patient is smoking marijuana, I would be seriously remiss if I failed to address the medical consequences with that patient. If I have information

that limited use of marijuana may provide relief from disabling symptoms, I feel duty-bound to provide that information. If I believe, in my clinical judgment, that the risks to that patient may be reduced if the marijuana is ingested by means other than smoking (*e.g.*, by eating baked goods or drinking a tea with marijuana infusion), I have a duty to provide that information as well. That knowledge is based on my scientific knowledge, clinical judgment, and common sense.

13. My knowledge and clinical judgment are informed by all credible sources, including the federal Food and Drug Administration. I was one of the principal investigators of an FDA-supervised trial conducted by Unimed, Inc. on the safety and efficacy of Marinol as an appetite stimulant in HIV/AIDS patients suffering from wasting syndrome. Marinol is a form of THC, one of the key active components of marijuana; it is essentially a marijuana extract. It was approved by the FDA five years ago, and has been widely prescribed by physicians treating both AIDS and cancer patients.

14. The current edition of the Physician's Desk Reference, the most widely-used and comprehensive authority on prescription medications, states that:

> Marinol (dronabinol) is indicated for the treatment of:
>
> 1. anorexia associated with weight loss in patients with AIDS; and
> 2. nausea and vomiting associated with cancer chemotherapy in patients who have failed to

> respond adequately to conventional antiemetic treatments.[1]

Stedman's Medical Dictionary, another highly respected and widely-used reference work, as part of its definition of "cannabis," includes the following:

> C[annabis] was formerly used as a sedative and analgesic; now available for restricted use in management of iatrogenic[2] anorexia, especially that associated with oncologic chemotherapy and radiation therapy.[3]

I am aware of no medical report that would indicate serious adverse effects arising from the clinical use of Marinol.

15. I am aware, however, that Marinol (like any medication) is not effective in treating all patients. In some cases, the reason is simple: Marinol is taken orally, in pill form. Patients suffering from severe nausea and retching cannot tolerate the pills and thus do not benefit from the drug. There are likely other reasons why smoked marijuana is sometimes more effective than Marinol. The body's absorption of the chemical may be faster or more complete when inhaled. Means of ingestion is often critical in understanding treatment efficacy. Research has revealed, for example, that insulin, which is critical in the treatment of diabetes, is rendered ineffective when taken orally.

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[1] *Physicians' Desk Reference*, 50th Edition (1996: Medical Economics), p. 2232.

[2] "Iatrogenic" conditions are those which result from medical treatments or procedures, such as chemotherapy-related nausea or weight loss.

[3] Spraycar, M. (ed.), *Stedman's Medical Dictionary*, 26th edition (1995: Williams & Wilkins), p. 269.

Medications commonly used to treat asthma and lung infections are routinely administered through inhalers. Marinol is not currently available in any form other than pills. These are scientific facts which inform my clinical practice. I cannot ignore them or deprive my patients of that knowledge.

16. I am aware that federal government officials have issued threats of criminal, civil and administrative sanctions against physicians who recommend the use of marijuana or counsel and advise patients regarding the clinical risks and benefits of marijuana. They have repeatedly stated that providing counsel and advice regarding the clinical use of marijuana is a violation of federal law. I see these public pronouncements as a threat to the integrity of my medical practice. While there are certainly limitations on my ability to obtain or prescribe medications, I cannot ethically withhold information or scientific data which may be of benefit to my patients. If I am prohibited from advising my patients on any matter affecting their health, I am unable to exercise clinical judgment and provide effective treatment.

17. Such interference in my communications with individual patients can do immeasurable damage to my relationship with specific patients, thereby undermining my ability to provide effective treatment generally. Without the element of mutual trust and protected confidentiality, many of my patients will be unable or unwilling to provide me with information essential to my medical assessment. As a result, I am disarmed in my struggle against illness and suffering. They are deprived of basic medical information which could inform their behavior and relieve their disabilities. In

light of the recent government threats, I have already limited my discussions with patients and directed my staff (including other physicians) to use extreme caution when obtaining medical histories or answering patient inquiries about marijuana. Even this degree of wariness and apprehension has a chilling effect on my rapport with patients. They see me as part of their fight for life. Government threats disarm me in that struggle, and it is my patients who will ultimately suffer.

18. I have already stated that marijuana has proven effective in addressing many symptoms caused by medically prescribed treatments. The adverse affects of these therapies are particularly troubling to both the patient and the physician. In my practice, I frequently recommend treatments which, in the short term, may result in increased discomfort and visible suffering. They may also have adverse implications for the patient's long-term health. I cannot, in good faith, recommend these procedures and medications without a professional commitment to decrease, prevent or reduce the effects of these conditions.

19. Failure to consider every possible means of alleviating adverse side effects has very serious implications. When a patient can no longer tolerate the adverse consequences, she or he will cease treatment. I have seen it many times in my own practice and my colleagues report it consistently. It is a tragic fact which we monitor and assess constantly. In the case of chemotherapy and many AIDS medications, terminating treatment can mean an early and often painful death. It results in hopelessness where there should be, or could be, hope. As a scientist and a healer,

preventable suffering and unnecessary despair are unacceptable.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge, and that this declaration was executed this 14 day of February, 1997 in San Diego, California.

/s/ MARCUS A. CONANT, M.D.
MARCUS A. CONANT. M.D.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Case No. C 97-0139 FMS

DR. MARCUS CONANT, DR. DONALD NORTHFELT, DR. ARNOLD LEFF, DR. DEBASISH TRIPATHY, DR. NEIL FLYNN, DR. STEPHEN FOLLANSBEE, DR. ROBERT SCOTT, III, DR. STEPHEN O'BRIEN, DR. MILTON ESTES, DR. VIRGINIA CAFARO, DR. HOWARD MACCABEE, JO DALY, KEITH VINES, JUDITH CUSHNER, VALERIE CORRAL, DANIEL KANE, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED, BAY AREA PHYSICIANS FOR HUMAN RIGHTS; AND BEING ALIVE: PEOPLE WITH AIDS/HIV ACTION COALITION, INC., PLAINTIFFS,

v.

BARRY R. MCCAFFREY, AS DIRECTOR, UNITED STATES OFFICE OF NATIONAL DRUG CONTROL POLICY; THOMAS A. CONSTANTINE, AS ADMINISTRATOR, UNITED STATES DRUG ENFORCEMENT ADMINISTRATION, JANET RENO, AS ATTORNEY GENERAL OF THE UNITED STATES, AND DONNA SHALALA, AS SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS

March 21, 1997
[Original Filed: Feb. 14, 1997]

DECLARATION OF
HOWARD D. MACCABEE, PH.D., M.D

I, DR. HOWARD D. MACCABEE, declare as follows:

1. I am a physician licensed to practice in the State of California. I have been Medical Director of the Radiation Oncology Center in Walnut Creek, California, for 17 years. I am also an Assistant Clinical Professor of Medicine at the University of California at San Francisco ("UCSF").

2. I received a B.S. from Purdue University in Lafayette, Indiana, in 1961. I received a Ph.D from the University of California at Berkeley in 1966. My dissertation research was on radiation biophysics. After extensive research in the areas of physics and medicine, I attended the University of Miami School of Medicine, where I earned a M.D. in 1975. I then completed my Internship at UCSF in 1976, followed by a three-year Residency in radiation oncology, also at UCSF.

3. I am board certified in therapeutic radiology and am a member of several professional societies. I have published 25 articles on diverse scientific and medical topics.

4. I have also studied the ethical aspects of the doctor-patient relationship and am on the bioethics committees of John Muir Medical Center and the Alameda-Contra Costa County Medical Association. I have chaired symposia on this issue between 1988 and 1994 in Contra Costa County.

5. In my practice, I commonly use radiation therapy to treat the whole spectrum of solid malignant tumors. Radiation therapy is often used after surgery or chemotherapy, as a second stage in treatment. Sometimes, however, radiation therapy is used concurrently with

chemotherapy, or even as the first or only modality of treatment.

6. I treat approximately 20 patients each day and provide follow-up care and/or consultation with another 5 or so patients a day. I currently have approximately 2,000 patients in various stages of follow-up to their initial treatment. Most of these are long-term survivors.

7. Because of the nature of some cancers, I must sometimes irradiate large portions of my patients' abdomens. Such patients often experience nausea, vomiting, and other side effects. Because of the severity of these side effects, some of my patients choose to discontinue treatment altogether, even when they know that ceasing treatment could lead to death.

8. During the 1980s, I participated in a state-sponsored study of the effects of marijuana and THC (an active ingredient in marijuana) on nausea. It was my observation during this time that some patients smoked marijuana while hospitalized, often with the tacit approval of physicians. I also observed that medical marijuana was clinically effective in treating the nausea of some patients.

9. During my career as a physician. I have witnessed cases where patients suffered from nausea or vomiting that could not be controlled by prescription anti-emetics. I frequently hear similar reports from colleagues treating cancer and AIDS patients. As a practical matter, some patients are unable to swallow pills because of the side effects of radiation therapy or chemotherapy, or because of the nature of the cancer

(for instance, throat cancer). For these patients, medical marijuana can be effective form of treatment.

10. I occasionally have patients who inquire about the use of medical marijuana. I have always considered it my ethical duty as a physician to provide every patient with the full truth as I know it. This duty includes informing patients about treatment options that I personally do not provide. For example, although I do not prescribe chemotherapy, it is my ethical obligation to discuss this treatment option with patients who are also considering undergoing radiation treatment. Because of the threats by federal officials against physicians who provide information to patients regarding the potential risks or benefits of the medical use of marijuana, I have had to reexamine this basic ethical principle for the first time in my professional career.

11. Due to fear caused by the threats of federal officials, I feel compelled and coerced to withhold information, refuse to make recommendations, and modify for non-clinical reasons my advice to patients regarding use of medical marijuana. Since the threats, I have not had any patients ask about medical marijuana. When I do receive such an inquiry, however, I will temper what I say to avoid the risk of government sanction. Based on my years of practice, I am concerned that my reticence in providing information will adversely affect the doctor-patient relationship, a result which is both regrettable and ethically substandard.

12. I understand that one of the reasons behind the threats is to deter physicians who may inappropriately recommend the use of medical marijuana. The threat of abuse in this context is no greater than the threat

posed by doctors who misprescribe or othewise act irresponsibly with regard to any drug. There will always be a small number of doctors who behave irresponsibly; those individual doctors should certainly be sanctioned, but not at the expense of the ability of responsible doctors to provide important medical information to their patients.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed at Walnut Creek, California, this 14th day of February, 1997.

/s/ HOWARD D. MACCABEE
HOWARD D. MACCABEE

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-0085 CRB
C 98-0086 CRB
C 98-0087 CRB
C 98-0088 CRB
C 98-0089 CRB
C 98-0245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANTS
AND RELATED ACTIONS

DECLARATION OFJOHN P. MORGAN, M.D.

I, JOHN P. MORGAN, declare:

1. I am a medical doctor and Professor of Pharmacology at the City University of New York Medical School. I have personal knowledge of the facts stated herein, and if called as a witness, I could and would testify competently as to them.

2. I am co-author of the book entitled "Marijuana Myths, Marijuana Facts—A Review of the Scientific Evidence," published in 1997.

3. Marijuana, also known as cannabis, has many proven medical uses. Medical cannabis reduces nausea and vomiting induced by cancer chemotherapy, stimu-

lates appetite and promotes weight gain in AIDS patients, reduces intraocular pressure in people suffering from glaucoma, reduces muscle spasticity in patients with neurological disorders, spinal cord injuries, and multiple sclerosis. Furthermore, patients and physicians have reported that smoked marijuana also provides relief from migraine headaches, depression, seizures, and pain.

4. Recent studies have shown that cannabinoids may also be useful for other neurological disorders, such as stroke.

5. There are no reasonable legal alternatives to medical cannabis for many patients. Delta-9-THC is the main active ingredient in marijuana. While synthetic THC is available in capsule form, it is not nearly as effective as smoked marijuana for many patients. For people suffering from nausea and vomiting, who are unable to swallow and hold down a pill, smoking marijuana is often the only reliable way to deliver THC to the body. Smoking marijuana delivers THC quickly, providing relief in a few minutes, compared to an hour or more when THC is swallowed.

6. Smoking marijuana not only delivers THC to the bloodstream more quickly than swallowing synthetic THC, but smoking delivers most of the THC inhaled. When synthetic THC is swallowed, 90 percent or more of it never reaches sites of activity in the body as a result of the body's extensive metabolism of swallowed THC.

7. Another problem with swallowed THC is that it effects vary considerably, both from one person to

another and in the same person from one episode of use to another. Further, because the onset of effect is an hour or more, patients using synthetic THC have difficulty achieving just the effective dose. Moreover, when THC is swallowed, the effects last longer (up to six hours) compared to one or two hours when marijuana is smoked. Thus, smoking marijuana is a more flexible route of administration than swallowing because smoking allows patients to adjust their dose to coincide with the rise and fall of symptoms. For people suffering from nausea and vomiting from AIDS or cancer chemotherapy, smoked marijuana provides rapid relief with lower overall doses of THC.

8. The psychoactive side effects of swallowed synthetic THC may be more intense than those that occur from smoking, thereby increasing the likelihood of adverse psychological reactions. This occurs because the liver actually produces, in high concentration, an active metabolite.

9. Smoking is a highly unusual way to administer a drug. Many drugs could be smoked, but there is no good reason to do so because oral preparations produce adequate blood concentrations. This is not the case with THC. Inhaling is a better route of administration than swallowing. Inhaling is about equal in efficiency to intravenous injection, and considerably more practical.

10. "Cannabis buyers' cooperatives" are the best and safest way for patients to obtain medical cannabis. Patients who rely on the criminal street markets to obtain marijuana necessarily acquire cannabis of unknown potency and purity. For example, marijuana purchased from a street dealer may contain fungal spores, which may be deadly for AIDS patients who have suppressed immune systems. As a result of the dangers of obtaining marijuana from the criminal market, some patients who need the drug may choose to forego their medication.

11. The Drug Enforcement Administration's own administrative law judge, Francis L. Young, concluded not only that marijuana's medical utility had been adequately demonstrated by the evidence, but that marijuana had been shown to be "one of the safest therapeutically active substances known to man." The DEA administrator ignored this opinion when he decided to maintain marijuana as a Schedule I drug.

12. For many patients medical cannabis is necessary to avert imminent and often life-threatening harm. For many patients, such as those undergoing intensive chemotherapy or experiencing AIDS-related "wasting syndrome," medical cannabis saves their lives. For patients suffering from glaucoma, medical cannabis may save their vision. For patients suffering neurological disorders resulting from spinal cord injuries and multiple sclerosis, medical cannabis may enable them to physically cope in society, to go on with their lives and to endure pain.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 13th day of August at New York, New York.

JOHN P. MORGAN
JOHN P. MORGAN, M.D.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 98-00085 CRB
C 98-00086 CRB
C 98-00087 CRB
C 98-00088 CRB
C 98 00089 CRB
C 98 00245 CRB

UNITED STATES OF AMERICA, PLAINTIFF

v.

CANNABIS CULTIVATOR'S CLUB, ET AL., DEFENDANT AND RELATED ACTIONS

DECLARATION OF LESTER GRINSPOON, M.D., IN SUPPORT OF DEFENDANTS' RESPONSE TO SHOW CAUSE ORDER

I, LESTER GRINSPOON, M.D., declare:

1. I am an Associate Professor of Psychiatry, at Harvard Medical School in Boston, Massachusetts, where I have taught for more than 35 years. I am also Editor of The Harvard Mental Health Letter. My area of research is psychoactive drugs. I am particularly interested in the medicinal properties of cannabis. If called as a witness, I could and would testify competently to the facts set forth below. I have attached a

copy of my *Curriculum Vitae* as Exhibit A. For the Court's convenience, where appropriate I have provided footnotes referencing the sources upon which I have relied.

2. I received a bachelor's degree in 1951 from Tufts College. I received a doctorate in 1955 from Harvard Medical School. I subsequently completed an internship in Medicine at Beth Israel Hospital in Boston, Massachusetts (1955-1956), and a residency in psychiatry at Massachusetts Mental Health Center (1958-1961). I received further training as a field instructor for the National Cancer Institute in Los Angeles, California (1956-1958).

3. Since joining the Harvard Medical School faculty in 1973, I have held numerous positions, including Associate Clinical Professor, Assistant Clinical Professor, and Senior Psychiatrist for the Massachusetts Mental Health Center. My other research and teaching appointments include, Assistant in Medicine for University of Southern California School of Medicine (1956-1958), Director of the Clinical Research Center for Massachusetts Mental Health Center (1961-1968), Consultant in Psychiatry and Research for Boston State Hospital (1963-1970) and an Examiner for the American Board of Psychiatry and Neurology (1969-present). I have also held several positions for the American Psychiatric Association such as Vice-Chairperson (1975-1977) and Chairperson for the Council on Research (1977-1979), Vice-Chairperson (1979-1980) and Chairperson for Scientific Program Committee (1980-1984).

4. I serve on several professional and community boards. These include many years as a member of the Beneficial Plant Research Association (1980-1984), the Drug Policy Foundation (1987-present), Physicians for Human Rights (1986-present), the Drug Research Group (1995-present), and Scientific and Policy Advisors of the American Council on Science and Health (1997-present). I recently served as Chairperson for the Board of Directors for the National Organization for the Reform of Marihuana Laws (1993-1995). I was also a faculty member for the Zinberg Center for Addiction Studies in Cambridge, Massachusetts (1993-1996). I am currently on several Editorial Boards, including editor for the Harvard Mental Health Letter (1984-present), the Journal of Social Pharmacology (1985-present), and Addiction Research (1991-present).

5. I have testified before the National Marijuana Commission Subcommittee of the Senate Small Business Committee in 1972, the House Select Committee on Narcotics in 1977, 1979 and 1989, the Controlled Substances Advisory Committee, the Drug Abuse Research Advisory Committee in 1978, the Senate Judiciary Committee in 1980, and the House Judiciary Committee, Sub-Committee on Crime in 1997. I am also a frequent presenter at national and international conferences.

6. I have authored and co-authored some 154 articles in scholarly and professional journals, most of which deal with clinical comparisons of drug therapies. I have contributed chapters of medical textbooks, research publications, clinical protocols and conference reports. My work has been published in the *Journal of Clinical Endocrinology and Metabolism, New England Journal*

of Medicine, Journal of the National Cancer Institute, Mental Patients in Transition, Science Digest, Archives of General Psychiatry, Comprehensive Psychiatry, Clinical Medicine, Journal of Psychiatric Research, Psychosomatic Medicine, Diseases of the Nervous System, American Journal of Psychiatry, Scientific America, Psychopharmacologia, International Journal of Psychiatry, Encyclopedia of Science and Technology, International Narcotic Report, New York Law Journal, Journal of Consulting and Clinical Psychology, Drug Therapy, World Journal of Psychosynthesis, Medical Tribune, Contemporary Drug Problems, Social Science and Medicine, Villanova Law Review, Congressional Digest, Biological Psychiatry, The Sciences, Journal of Ethnopharmacology, Handbook on Drug Abuse, The Hastings Center Report, Harvard Mental Health Letter, Harper's, Nova Law Review, New Harvard Guide to Psychiatry, Journal of State Government, Cancer Treatment & Marijuana Therapy, Journal of Drug Issues, North Carolina Journal of International Law & Commercial Regulation, Encyclopedia of Human Biology, Drugs, Society and Behavior, Journal of American Medical Association, University of West Los Angeles Law Review, and *Journal of Psychoactive Drugs.*

7. I have authored and co-authored some 13 books, several of which deal with the history and medical use of cannabis. These books include *Marihuana Reconsidered* (Harvard University Press, 2d ed. 1977), *Psychedelic Drugs Reconsidered* (Basic Books, 2d ed. 1981), *Psychedelic Reflections* (Human Sciences Press, 1982), *The Long Darkness: Psychological and Moral Perspectives on Nuclear Winter* (Yale University

Press, 1986), and *Marihuana, The Forbidden Medicine* (Yale University Press, Revised Edition 1997).

8. Based on my research, I have found that cannabis is remarkably safe. Although not harmless, it is surely less toxic than most of the conventional medicines it could replace if it were legally available. Despite its use by millions of people over thousands of years, cannabis has never caused an overdose death. The most serious concern is respiratory system damage from smoking, but that can easily be addressed by increasing the potency of cannabis and by developing the technology to separate the particulate matter in marijuana smoke from its active ingredients, the cannabinoids (prohibition, incidentally, has prevented this technology from flourishing). Once cannabis regains the place in the U.S. Pharmacopoeia that it lost in 1941 after the passage of the Marihuana Tax Act (1937), it will be among the least toxic substances in that compendium. Right now the greatest danger in using cannabis medically is the illegality that imposes a great deal of anxiety and expense on people who are already suffering.

9. I have done extensive research on the history of the use of cannabis for medical purposes, as well as its legal regulation in the United States. The marijuana, cannabis, or hemp plant is one of the oldest psychoactive plants known to humanity. A native plant of central Asia, cannabis may have been cultivated as much as ten thousand years ago. It was certainly cultivated in China by 4000 B.C. and in Turkestan by 3000 B.C. It has long been used as a medicine in India, China, the Middle East, Southeast Asia, South Africa, and South America. The first evidence of the medicinal

use of cannabis was published during the reign of the Chinese Emperor Chen Nun five thousand years ago. Cannabis was recommended for, among other things, malaria and rheumatic pains. Another Chinese herbalist recommended a mixture of hemp, resin, and wine as an analgesic during surgery. Hemp was also noted as a remedy by Galen and other physicians of the classical and Hellenistic eras, and it was highly valued in medieval Europe.

10. Between 1840 and 1900, more than one hundred papers on the therapeutic uses of cannabis were published in American and European medical journals. It was recommended as an appetite stimulant, muscle relaxant, analgesic, sedative, anticonvulsant, and as a treatment for opium addiction. A professor at the Medical College of Calcutta, W.B. O'Shaughnessy, was the first Western physician to observe the use of cannabis as a medicine. He gave cannabis to animals, satisfied himself that it was safe, and began to use it with patients suffering from rabies, rheumatism, epilepsy, and tetanus. In a report published in 1839, he wrote that he had found tincture of hemp (a solution of cannabis in alcohol, taken orally) to be an effective analgesic. He was also impressed with its muscle relaxant properties and called it "an anticonvulsive remedy of the greatest value." In 1890, J.R. Reynolds, a British physician, summarized thirty years of experience with *Cannabis indica*, finding it valuable in the treatment of various forms of neuralgia, including tic douloureux (a painful facial neurological disorder), and added that it was useful in preventing migraine attacks. He also found it useful for certain kinds of epilepsy, for depression, and sometimes for asthma and dysmenorrhea.

11. The medical use of cannabis was in decline by 1890. It was believed that the potency of cannabis preparations was too variable, and that individual responses to orally ingested cannabis seemed erratic and unpredictable. Another reason for the neglect of research on the analgesic properties of cannabis was that the greatly increased use of opiates after the invention of the hypodermic syringe in the 1850s allowed soluble drugs to be injected for faster pain relief; hemp products are insoluble in water and so cannot easily be administered by injection. Toward the end of the nineteenth century, the development of such synthetic drugs as aspirin, chloral hydrate, and barbiturates, also contributed to the decline of cannabis as a medicine. But these new drugs had, and still have today, striking disadvantages. More than a thousand people die from aspirin-induced bleeding each year in the United States, and barbiturates are, or course, far more dangerous.

12. Cannabis use in the United States was particularly a matter of state or federal regulation until 1915, when the first state, California, prohibited marijuana possession or sale. In 1930, the year in which the Federal Bureau of Narcotics was founded, only sixteen states had laws prohibiting the use of cannabis. In contrast, by 1937, nearly every state had adopted legislation outlawing cannabis. Sociologists have speculated that pressure from the liquor lobby figured among the more subtle factors in this sudden legal onslaught. More important, lack of scientific understanding concerning the effects of cannabis enabled the unsubstantiated statements of the Federal Bureau of Narcotics to go substantially unchallenged. The Marihuana Tax Act of 1937 was the culmination of a series of

efforts on the part of the Federal Bureau of Narcotics to generate anti-marijuana legislation.

13. One might have expected physicians looking for better analgesics and hypnotics to turn to cannabinoid substances, but the Marihuana Tax Act of 1937 undermined any such experimentation. The Marihuana Tax Act of 1937 imposed a transfer tax upon certain dealings in marijuana. The Marihuana Tax Act of 1937 provided that anyone who imports, manufactures, produces, compounds, sells, deals in, dispenses, prescribes, administers, or gives away marijuana was required to register, record transactions and pay special taxes depending on the defined purposes. Those who failed to comply were subject to large fines or prison for tax evasion. Although, it was ostensibly designed to prevent nonmedical use of cannabis, the Marihuana Tax Act of 1937 made cannabis so difficult to obtain, that cannabis was removed from the United States Pharmacopoeia and National Formulary in 1941. The Boggs Act of 1951 established mandatory prison terms and large fines for violation of any federal drug law, and the Narcotic Control Act of 1956 strengthened those penalties.

14. In the 1960s, however, the public began to rediscover the medical value of cannabis, as letters appeared in lay publications from people who had learned that it could relieve their asthma, nausea, muscle spasms, or pain and wanted to share that knowledge with readers who were familiar with the drug. Meanwhile, legislative concern about recreational use of cannabis increased, and in 1970 Congress passed the Comprehensive Drug Abuse Prevention and Control Act (also called the Controlled Substances Act), which

assigned psychoactive drugs to five schedules and placed cannabis in Schedule I, the most restrictive.

15. A few patients have been able to obtain medical cannabis legally in the last twenty years. Beginning in the 1970s, thirty-five states passed legislation that would have permitted medical use of cannabis but for the federal law. Several of those states actually established special research programs, with the permission of the federal government, under which patients who were receiving cancer chemotherapy would be allowed to use cannabis. These projects demonstrated the value of both smoked marijuana and oral THC (tetrahydrocannabinol). The FDA approved oral THC (Marinol) as a prescription medicine in 1986. In 1976, the federal government introduced the Individual Treatment Investigational New Drug program (commonly referred to as the Compassionate IND), which provided cannabis to a few patients whose doctors were willing to undergo the paperwork-burdened and time-consuming application process. About three dozen patients eventually received cannabis before the program was discontinued in 1992, and eight survivors are still receiving it—the only persons in the country for whom it is not a forbidden medicine.

16. The most effective spur to the movement for medical marijuana came from the discovery that it could prevent the AIDS wasting syndrome. It is not surprising that the Physicians Association for AIDS Care was one of the medical organizations that endorsed the California initiative prohibiting criminal prosecution of medical marijuana users.

17. I have conducted an extensive review of the literature concerning medical uses of cannabis and I am familiar with studies on the topic. Review of medical literature is a commonly used research tool. I have also studied clinically many patients who have used cannabis for the relief of a variety of symptoms; this clinical experience forms the basis of my book, *Marihuana, The Forbidden Medicine*. In my book I provide first-person accounts of the ways that cannabis alleviates symptoms of cancer chemotherapy, multiple sclerosis, osteoarthritis, glaucoma, AIDS and depressions, as well as symptoms of such less common disorders as Crohn's disease, diabetic gastroparesis, and post-traumatic stress disorder. The patient narratives illustrate not only cannabis's therapeutic properties but also the unnecessary further pain and anxiety imposed on sick people who must obtain cannabis illegally.

18. Cannabis has several uses in the treatment of cancer. As an appetite stimulant, it can help to slow weight loss in cancer patients. It may also act as a mood elevator. But the most common use is the prevention of nausea and vomiting associated with cancer chemotherapy. About half of patients treated with anticancer drugs suffer from severe nausea and vomiting, which are not only unpleasant and painful but a threat to the effectiveness of the therapy. Retching can cause tears of the esophagus and rib fractures, prevent adequate nutrition, and lead to fluid loss. Some patients find the nausea so intolerable they say they would rather die than go on. The antiemetics most commonly used in chemotherapy are metoclopramide (Reglan), the relatively new ondansetron (Zofran), and the newer granisetron (Kytril). Unfortunately, for

many cancer patients these conventional antiemetics do not work at all or provide little relief.

19. The suggestion that cannabis might be used in the treatment of cancer arose in the early 1970s when some young patients receiving cancer chemotherapy found that marijuana smoking reduced their nausea and vomiting. In one study of 56 patients who got no relief from standard antiemetic agents, 78% became symptom-free when they smoked marijuana.[1] Oral tetrahydrocannabinol (THC) has proved effective where the standard drugs were not,[2] but smoking generates faster and more predictable results because it raises THC concentration in the blood more easily to the needed level. Also, it may be hard for a nauseated patient to take oral medicine. In fact, there is strong evidence that most patients suffering from nausea and vomiting prefer smoked marijuana to oral THC.

20. Oncologists may be ahead of other physicians in recognizing the therapeutic potential of cannabis. In the spring of 1990, two investigators randomly selected more than 2,000 members of the American Society of Clinical Oncology (one-third of the membership and mailed them an anonymous questionnaire to learn their views on the use of cannabis in cancer chemotherapy. Almost half of the recipients responded. Although the

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[1] Vinciguerra, V., et al. Inhalation Marihuana as an antiemetic for cancer chemotherapy. *New York State Journal of Medicine* 1988; 88:525-527 (Attached as Exhibit B).

[2] Sallan, S.E., et al. Antiemetic effect of delta-9-tetrahydrocannabinol in patients receiving cancer chemotherapy. *New England Journal of Medicine* 1975; 293:795-797 (Attached as Exhibit C).

investigators acknowledged that this group was self-selected and that there might be a response bias, their results provide a rough estimate of the views of specialists on the use of Marinol (dronabinol, oral synthetic THC) and smoked marijuana. Only 43% said the available legal antiemetic drugs (including Marinol) provided adequate relief to all or most of their patients, and only 46% said the side effects of these drugs were rarely a serious problem. Forty-four percent had recommended the illegal use of cannabis to at least one patient, and half would prescribe it to some patients if it were legal. On average, they considered smoked marijuana more effective than Marinol and roughly as safe.[3]

21. Cannabis is also useful in the treatment of glaucoma, the second leading cause of blindness in the United States. In this disease, fluid pressure within the eyeball increases until it damages the optic nerve. About a million Americans suffer from the form of glaucoma (open angle) treatable with cannabis. Glaucoma is treated chiefly with eyedrops containing beta-blockers such as timolol (Timoptic), which inhibit the activity of epinephrine (adrenaline). They are effective but may have serious side effects such as inducing depression, aggravating asthma, slowing the heart rate, and increasing the risk of heart failure. Cannabis causes a dose-related, clinically significant drop in intraocular pressure that lasts several hours in both normal subjects and those with the abnormally high ocular tension produced by glaucoma. Oral or intravenous THC has the same effect, which seems to be specific to

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[3] Doblin R. Kleiman M. Marihuana as anti-emetic medicine: a survey of oncologists' attitudes and experiences. *Journal of Clinical Oncology* 1991; 9:1275-80 (Attached as Exhibit D).

cannabis derivatives rather than simply a result of sedation. Cannabis does not cure the disease, but it can retard the progressive loss of sight when conventional medication fails and surgery is too dangerous.[4]

22. About 20% of epileptic patients do not get much relief from conventional anticomvlsant medications. Cannabis has been explored as an alternative at least since 1975 when a case was reported in which marijuana smoking, together with the standard anticonvulsants Phenobarbital and diphenylhydantoin, was apparently necessary to control seizures in a young epileptic man.[5] The cannabis derivative that is most promising as an anticonvulsant is cannabidiol. In one controlled study, cannabidiol in addition to prescribed anticonvulsants produced improvement in seven patients with grand mal convulsions; three showed great improvement. Of eight patients who received a placebo instead, only one improved.[6] There are patients suffering from both grand mal and partial seizure disorders who find that smoked marijuana allows them to lower the doses of conventional anticonvulsant medications or dispense with them altogether. Furthermore, anticonvulsants have many potentially serious side effects, including bone softening, anemia, swelling of the gums, double vision, hair loss, headaches, nausea, decreased

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[4] Hepler, R.S., et al. Ocular Effects of Marihuana Smoking. M.C. Braude, S. Szara (eds.). *The Pharmacology of Marihuana*, New York: Raven Press, 1976.

[5] Consroe, Paul F., et al. Anticonvulsant nature of Marihuana smoking. *Journal of the American Medical Association* 1975; 234-306-307. (Attached as Exhibit E).

[6] Cunha, J.M., et al. Chronic administration of cannabidiol to healthy volunteers and epileptic patients. *Pharmacology* 1980; 21:175-185. (Attached as Exhibit F).

libido, impotence, depression, and psychosis. Overdoses or idiosyncratic reactions may lead to loss of motor coordination, coma or even death.

23. There are many case reports of cannabis smokers using the drug to reduce pain: post-surgery pain, headache, migraine, menstrual cramps, and so on. Ironically, the best alternative analgesics are the potentially addictive and lethal opioids. In particular, cannabis is becoming increasingly recognized as the most effective treatment for the pain that accompanies muscle spasm which is often chronic and debilitating, especially in paraplegics, quadriplegics, other victims of traumatic nerve injury, and people suffering from multiple sclerosis or cerebral palsy. Many of them have discovered that cannabis not only allows them to avoid the risks of other drugs, but also reduces muscle spasms and tremors; sometimes they are even able to leave their wheelchairs.[7]

24. One of the most common causes of chronic pain is osteoarthritis, which is usually treated with synthetic analgesics. The most widely used of these drugs—aspirin, acetaminophen (Tylenol), and nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen and naproxen—are not addictive, but they are often insufficiently powerful. Furthermore, they have serious side effects. Stomach bleeding and ulcer induced by aspirin and NSAIDs are the most common serious adverse drug reactions reported in the United States, causing an estimated 7,000 deaths each year. Acetaminophen

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[7] Petro, D.J., Ellenberger, C., Treatment of human spasticity with delta-9-tetrahydrocannabinol. *Journal of Clinical Pharmacology* 1981; 21:413-416. (Attached as Exhibit G).

can cause liver damage or kidney failure when used regularly for long periods of time; a recent study suggests it may account for 10% of all cases of end-stage renal disease, a condition that requires dialysis or a kidney transplant.[8] Cannabis, as I pointed out earlier, has never been shown to cause death or serious illness. The University of Iowa conducted a study of cannabis for the relief of pain. Researchers gave oral THC or placebo at random to hospitalized cancer patients who were in severe pain. The THC relieved pain for several hours in doses as low as 5-10 mg, and for even longer at 20 mg. At this dose and in this setting, THC proved to be a sedative as well. It had few physical side effects than other commonly used analgesics.[9]

25. Oncologists are legally permitted to administer the synthetic THC (Marinol) orally in capsule form. But inhaled cannabis may be necessary for several reasons. For one thing, oral THC is subject to the variances of bioavailability. This means that two patients who take the same amount may absorb different proportions of the dose, and a given patient may respond differently on different days, depending on the condition of the intestinal tract and other factors. Furthermore, the effects of smoked cannabis are perceived almost immediately, so patients can smoke

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[8] Perneger, T.V., Whelton, P., Klag, M.J. Risk of kidney failure associated with the use of acetaminophen, aspirin, and nonsteroidal anti-inflammatory drugs. *New England Journal of Medicine*, 1994; 331:25:1675-1679. (Attached as Exhibit H).

[9] R. Noyes, S.F. Brunk, D.A. Baram, and A. Canter, "Analgesic Effect of Delta-9-tetrahydrocannabinol," *Journal of Clinical Pharmacology 15* (February-March 1975): 139-143. (Attached as Exhibit I).

slowly and take only what they need for a therapeutic effect. Patients who swallow Marinol may discover after an hour or so that they have taken too much for comfort or not enough to relieve their symptoms. In any case, a patient who is severely nauseated and constantly vomiting may find it almost impossible to the capsule down. Furthermore, Marinol makes some patients anxious and uncomfortable. Smoked cannabis, unlike Marinol, contains other substances which reduces anxiety caused by the THC.

26. In theory, all the therapeutic properties of cannabis could be used if individual cannabinoids in addition to THC were isolated and made available separately as medicines. But this would be an enormously complicated procedure. Research sponsors would have to determine the therapeutic potential and evaluate the safety of sixty or more substances, synthesize each one found to be useful, and package it as a pill or aerosol. As some of these substances probably act synergistically, it would also be necessary to look at various combination of them. However no drug company would provide the resources deeded for such a project because cannabis can not be patented, it is a plant material containing many chemicals rather than a single one and no drug in the present pharmacopoeia is delivered by smoking.

27. More than 300,000 Americans have died of AIDS. Nearly a million are infected with HIV, and at least a quarter of a million have AIDS. Although the spread of AIDS has slowed among homosexual men, the reservoir is so huge that the number of cases is sure to grow. Women and children as well as both heterosexual and homosexual men are now being affected; the

disease is spreading most rapidly among intravenous drug abusers and their sexual partners. The disease can be attacked with anti-viral drugs, of which the best known are zidovudine (AZT) and protease inhibitors. Unfortunately, these drugs sometimes cause severe nausea that heightens the danger of semi-starvation for patients who are already suffering from nausea and losing weight because of the illness—a condition sometimes called the AIDS wasting syndrome.

28. Cannabis is particularly useful for patients who suffer from AIDS because it not only relieves the nausea but retards weight loss by enhancing appetite. In one study the body weight and caloric intake of twenty-seven marijuana users and ten control subjects were compared for twenty-one days on a hospital research ward. The marijuana smokers ate more than the controls and gained weight; the controls did not. When they stopped smoking marijuana, they immediately started to eat less.[10] When it helps patients regain lost weight, it can prolong life. Although Marinol has been shown to relieve nausea and retard or reverse weight loss in patients with HIV infection, most patients prefer smoked cannabis for the same reasons that cancer chemotherapy patients prefer smoked cannabis. Cannabis is more effective and has fewer unpleasant side effects, and the dosage is easier to adjust. Many patients report that cannabis provides an appetite and pain relief without the semi-comatose effect of narcotics.

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[10] I. Greenberg, J. Kuehnle, J. H. Mendelson, and J.G. Bernstein, "Effects of Marijuana Use of Body Weight and Caloric Intake in Humans," *Journal of Psychopharmacology* (Berlin) 49 (1976): 79-84. (Attached as Exhibit J).

29. Opponents of medical cannabis often object that the evidence of its usefulness, although strong, comes only from case reports and clinical experience. It is true that there are no double-blind controlled studies meeting the standards of the Food and Drug Administration, chiefly because legal, bureaucratic, and financial obstacles have been constantly put in the way. However, we know more about cannabis than about most prescription drugs. Furthermore, individual therapeutic responses are often obscured in group experiments, and case reports and clinical experience are the source of much of our knowledge of drugs. As Dr. Louis Lasagna has pointed out, controlled experiments were not needed to recognize the therapeutic potential of chloral hydrate, barbiturates, aspirin, insulin, or penicillin.[11] Nor was that the way we learned about the use of propranolol for hypertension, diazepam for status epilepticus, and imipramine for enuresis. All these drugs had originally been approved for other purposes.

30. In the experimental method known as the single patient randomized trial, active and placebo treatments are administered randomly in alternation or succession. The method is often used when large-scale controlled studies are inappropriate because the disorder is rare, the patient is atypical, or the response to treatment is idiosyncratic.[12] Several patients have told me that they

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[11] Lasagne, L. Clinical trials in the natural environment. C. Stiechele, W. Abshagan, J. Kich-Weser (eds.). *In Drugs Between Reserach and Regulations*. New York: Springer-Verlag, 1985: 45-49. (Attached as Exhibit K).

[12] Larson, E.B. N-of-1 clinical trials: A technique for improving medical therapeutics. *Western Journal of Medicine* 1990; 152:52-56; Guyatt, G. H. Keller, J.L., Jaeschke, R., et al. The N-of-1

assured themselves of cannabis's effectiveness by carrying out such experiments on themselves, alternating periods of cannabis use with periods of abstention. I am convinced that the medical reputation of cannabis is derived partly from similar experiments conducted by many other patients.

31. Some physicians may regard it as irresponsible to advocate use of a medicine on the basis of case reports, which are sometimes disparaged as merely "anecdotal" evidence which counts apparent successes and ignores apparent failures. That would be a serious problem only if cannabis were a dangerous drug. The years of effort devoted to showing that cannabis is exceedingly dangerous have proved the opposite. It is safer, with fewer serious side effects than most prescription medicines, and far less addictive or subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics.

32. Based on the best available medical information, it is evident that cannabis should be made available even if only a few patients could get relief from it, because the risks are so small. For example, as I mentioned, many patients with multiple sclerosis find that cannabis reduces their muscle spasma and pain. A physician may not be sure that such a patient will get more relief from cannabis than from the standard drugs baclofen, dantrolene, and diazepam—all of which are potentially dangerous or addictive—but it is almost certain that a serious toxic reaction to cannabis will not

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radomized controlled trial: Clinical usefulness. *Annals of Internal Medicine* 1990; 112:293-299 (Attached as Exhibit L).

occur. Therefore the potential benefit is much greater than any potential risk.

33. During the past few years, the medical uses of cannabis have become increasingly clear to many physicians and patients, and the number of people with direct experience of these uses has been growing. Therefore, the discussion is now turning from whether cannabis is an effective medicine to how it should be made available.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 11th day of September, 1998. at Boston, Massachusetts.

/s/ LESTER GRINSPOON, M.D.
LESTER GRINSPOON, M.D.

INTRODUCED BY COUNCILMEMBER _____

Approved As To Form

[Signature illegible]
City Attorney

ORDINANCE NO. 12076 C.M.S.

AN ORDINANCE OF THE CITY OF OAKLAND ADDING CHAPTER 8.42 TO THE OAKLAND MUNICIPAL CODE PERTAINING TO MEDICAL CANNABIS

The City Council of the City of Oakland does ordain as follows:

Article 1. Chapter 8.42 is hereby added to the Oakland Municipal Code to read as follows:

MEDICAL CANNABIS

Section 1. Findings and Purposes

A. On November 5, 1996, the voters of the State of California adopted by initiative the Compassionate Use Act of 1996, codified at Health and Safety Code Section 11362.5, pertaining to medical use of marijuana. As stated therein, the purposes of the Compassionate Use Act of 1996 are in part to "ensure that seriously ill Californians have the right to obtain and use marijuana

for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief" and to "ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction." The City of Oakland supports the use of medical cannabis in accordance with the Compassionate Use Act of 1996. The purposes of the compassionate Use Act of 1996 are herewith also made purposes of this Chapter.

B. Long before the passage of the Compassionate Use Act of 1996, the City of Oakland was on record as being in support of medical cannabis and in support of Oakland medical cannabis providers, as exemplified by unanimously passed Oakland City Council Resolutions numbered 72379 C.M.S. and 72516 C.M.S.

C. The purpose of this Chapter is to recognize and protect the rights of qualified patients, their caregivers, physicians, and medical cannabis provider associations, and to ensure access to safe and affordable medical cannabis pursuant to the Compassionate Use Act of 1996. In support of this purpose, the City of Oakland recognizes that a medical cannabis provider association, as defined herein, may provide educational information concerning access to safe, affordable, and lawful medical cannabis, and may also distribute safe and affordable medical cannabis in a consistent, reliable, and legal fashion.

D. An additional purpose of this Chapter is to provide immunity to medical cannabis provider associations pursuant to Section 885(d) of Title 21 of the United States Code, which provides that no liability shall be imposed under the federal Controlled Substance Act upon any duly authorized officer of a political subdivision of a state lawfully engaged in the enforcement of any municipal ordinance relating to controlled substances.

Section 2. Definitions

The following words and phrases, whenever used in this Chapter, shall be construed as herein defined.

A. Qualified Patient: "Qualified patient" means a person who obtains a written or oral recommendation or approval from a physician to use cannabis for personal medical purposes.

B. Primary Caregiver: "Primary caregiver" means the person or persons designated by a qualified patient who have consistently assumed responsibility for the housing, health, or safety of that qualified patient.

C. Cannabis: "Cannabis" means marijuana and all parts of the plant Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted

therefrom), fiber, oil, or cake, or the sterilized seeds of the plant that are incapable of germination.

D. Medical Cannabis Provider Association: "Medical cannabis provider association" means a cooperative, affiliation, association, or collective of persons who are qualified patients or primary caregivers, the main purposes of which are to provide education, referral, or network services, and to facilitate or assist in the lawful production, acquisition, and distribution of medical cannabis. An entity may function as a medical cannabis provider association only if designated as such by the City of Oakland pursuant to Section 3 of this Chapter.

E. Officer: "Officer" means designee and shall not have the meaning of that term as used in Section 400 of the Oakland City Charter.

Section 3. Medical Cannabis Distribution Program

The City of Oakland hereby establishes a Medical Cannabis Distribution Program. Such program shall be administered by medical cannabis provider associations. The City Manager shall designate one or more entities as a medical cannabis provider association. Any designated medical cannabis provider association shall enforce the provisions of this Chapter, including enforcing its purpose of insuring that seriously ill Californians have the right to obtain and use marijuana for medical purposes. For the purposes of this Chapter only, a medical cannabis provider association, and its agents, employees and directors while acting within the scope of their duties on behalf of the association, shall be deemed officers of the City of Oakland.

Section 4. No Liability

To the fullest extent permitted by law, the City of Oakland shall assume no liability whatsoever, and expressly does not waive sovereign immunity, with respect to the Medical Cannabis Distribution Program established herein, or for the activities of any medical cannabis provider association. Each medical cannabis provider association designated by the City shall (1) indemnify the City of Oakland; (2) carry insurance in the amounts and of the types that are acceptable to the City's Risk Manager; and (3) name the City as an additional insured.

Section 5. Qualified Patients, Primary Caregivers, and Medical Cannabis Provider Associations

In order to ensure that qualified patients and primary caregivers are not subject to criminal prosecution or sanction, and to ensure that only qualified patients and primary caregivers have access to medical cannabis, the City of Oakland, or medical cannabis provider associations on behalf of the City of Oakland, may issue valid identification cards to qualified patients and primary caregivers upon receipt of a physician's recommendation or approval for medical cannabis.

Section 6. Physician-Patient Confidentiality

Certification processes conducted pursuant to this Chapter shall preserve to the maximum extent possible all legal protections and privileges, consistent with reasonably verifying the qualifications and status of qualified patients and primary caregivers. Disclosure of any patient information to assert facts in support of a

qualified status shall not be deemed a waiver of confidentiality of that information under any provision of law.

Section 7. Transportation of Medical Cannabis

All activities entailing the transportation of medical cannabis, in accordance with this Chapter, shall be lawful when conducted by qualified patients, primary caregivers, or medical cannabis provider associations where the quantity transported and the method, timing, and distance of the transportation are reasonably related to the medical needs of qualified patients.

Section 8. Miscellaneous Applications

Possession and use of the following items shall be lawful when used in accordance with the Compassionate Use Act of 1996 or this Chapter:

A. Pipes, papers, water pipes, vaporizers, and other related paraphernalia:

B. Cannabis products, such as baked goods, tinctures, concentrated cannabis, infusions, oils, salves, and any other cannabis derivatives.

Section 9. Violations and Penalties

A violation of any provision of this Chapter shall be a misdemeanor.

Article 2. Severability

If any provision of this Chapter, or the application thereof to any person or circumstance, is held invalid, that invalidity shall not affect any other provision or application of this Chapter that can be given effect without the invalid provision or application; and to this end, the provisions or applications of this Chapter are severable.

I certify that the foregoing is a full, true and correct copy of an Ordinance passed by the City Council of the City of Oakland, California on

July 28, 1998

CEDA FLOYD
City Clerk and Clerk of the Council

Per [Signature illegible] Deputy

CITY OF OAKLAND [Seal Omitted]

CITY HALL • ONE CITY HALL PLAZA • OAKLAND, CALIFORNIA 9461 [Illegible]

Office of City Manager (510) 238-330 [Illegible]
Robert C. Bobb FAX (510) 238-222 [Illegible]
City Manager TY/TDD (510) 238-372 [Illegible]

August 11, 1998

Mr. Jeff Jones
Executive Director
Oakland Cannabis Buyers' Cooperative
1755 Broadway, Suite 300
Oakland, CA 94612

Dear Mr. Jones:

Pursuant to Chapter 8.42 of the Oakland Municipal Code, the City hereby designates the Oakland Cannabis Buyers Club to administer the City's Medical Cannabis Distribution Program. The designation is subject to the cooperative's agreement to comply with the terms and conditions attached hereto as Exhibit A which hereby are incorporated by reference in this letter as if set forth in full herein.

The designation shall be effective upon the Oakland Cannabis Buyers' Cooperative's acceptance and agreement to the terms and conditions in Exhibit A. Please confirm the Oakland Cannabis Buyers' Cooperative's

agreement to comply with the terms and conditions in Exhibit A by signing below.

Very truly yours,

for [Illegible]
Robert C. Bobb
City Manager

SO AGREED:

JEFF JONES DATE: 8/12/98
JEFF JONES
Executive Director
Oakland Cannabis Buyers' Cooperative

OAKLAND CITY COUNCIL

RESOLUTION NO. 74618 C.M.S.

RESOLUTION DECLARING A LOCAL PUBLIC HEALTH EMERGENCY WITH RESPECT TO SAFE, AFFORDABLE ACCESS TO MEDICAL CANNABIS IN THE CITY OF OAKLAND

WHEREAS, on November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, by a YES vote of 55.7 percent, and the residents of Oakland voted YES for Proposition 215 by an overwhelming 79.3 percent; and

WHEREAS, marijuana has been shown to help alleviate pain and discomfort in people suffering from a variety of illnesses including AIDS, cancer, glaucoma, and multiple sclerosis when no other medications have been effective; and

WHEREAS, the City Council of the City of Oakland finds that many of Oakland's residents are suffering from life-threatening or serious illnesses whose painful symptoms are alleviated by the ingestion of cannabis; and

WHEREAS, there is a need to ensure that patients have access to a safe and affordable supply of medical grade marijuana and cannabis products; and

WHEREAS, the City Council finds that the Oakland Cannabis Buyers' Cooperative has provided a well-

organized, safe and responsible opportunity for seriously ill persons to obtain medical cannabis in furtherance of a course of medical treatment; and

WHEREAS, the Oakland City Council passed Resolution 72516 C.M.S. supporting the activities of the Oakland Cannabis Buyers Cooperative and declaring it to be the policy of the City of Oakland that the investigation and arrest of certain individuals involved with the medical use of marijuana shall be a low priority for the City of Oakland; and

WHEREAS, in furtherance of the City's goal of ensuring a safe and affordable supply of medical grade marijuana and cannabis products for seriously ill Oakland residents whose physicians have recommended or approved medical cannabis use in the treatment of their illnesses, the Oakland City Council, pursuant to Ordinance No. 12076, established a City of Oakland marijuana distribution program and designated the Oakland Cannabis Buyers' Cooperative as the City's agent to administer the program; and

WHEREAS, in January 1998, the United States of America filed an action asking the federal district court to enjoin the Oakland Cannabis Buyers' Cooperative and five other entities from providing medical cannabis to seriously ill persons who are authorized by Proposition 215 to use medical cannabis to alleviate their pain and suffering; and

WHEREAS, on May 19, 1998 the federal district court issued a preliminary injunction ordering the Oakland Cannabis Buyers' Cooperative to cease engaging in the manufacture and distribution of marijuana, on the

ground that such activities likely violate federal drug laws; and

WHEREAS, on October 13, 1998 the federal district court authorized the U.S. Marshal to enforce the aforesaid preliminary injunction by entering the cooperative's premises located at 1755 Broadway in Oakland, evicting any and all tenants and padlocking the doors to such premises; and

WHEREAS, on October 19, 1998, the Oakland Cannabis Buyers' Cooperative voluntarily ceased its operations at 1755 Broadway; and

WHEREAS, the Oakland Cannabis Buyers' Cooperative provided medical cannabis to two thousand two hundred (2,200) seriously ill persons, approximately two-thirds of whom are living with AIDS; and

WHEREAS, the closure of the Oakland Cannabis Buyers' Cooperative impairs public safety by encouraging a market for street narcotic peddlers to prey upon Oakland's ill residents by selling them marijuana that may be contaminated and will be of unknown content and potency; and

WHEREAS, the City Council finds that the closure of the Oakland Cannabis Buyers' Cooperative will cause pain and suffering to seriously ill Oakland residents who are unable to cultivate medical strains of cannabis for their personal use and therefore either no longer have access to medical cannabis to alleviate their pain and suffering or purchase contaminated cannabis from street narcotic peddlers;

NOW THEREFORE, be it

RESOLVED: that the City Council of the City of Oakland finds that a public health emergency exists with respect to access to an affordable and safe supply of medical cannabis, and pursuant to Government Code section 8630 does so declare; and be it further

RESOLVED: that the City Council finds that the thousands of seriously ill persons who obtained medical cannabis from the Oakland Cannabis Buyers' Cooperative will endure great pain and suffering and in some cases may die as a result of the closure of the cooperative and other entities that supplied medical cannabis; and be it further

RESOLVED: that the City Council of the City of Oakland urges the federal government to desist from any and all actions that pose obstacles to access to cannabis for Oakland residents whose physicians have determined that their health will benefit from the use of marijuana and recommended or approved medical cannabis use for such residents; and be it further

RESOLVED: that the City Council urges the Alameda County Board of Supervisors to declare a public health emergency with respect to access to medical cannabis; and be it further

RESOLVED: that copies of this resolution shall be forwarded to Senators Boxer and Feinstein, Congresswoman Lee, and the President of the United States, William Jefferson Clinton, urging federal policy-makers to dismiss the current lawsuits against California's

cannabis buyers' clubs and cooperatives; and be it further

RESOLVED: that copies of this resolution shall be forwarded to Governor Pete Wilson, Attorney General Daniel Lungren and all representatives of the City of Oakland in the State Legislature, urging them to comply with the will of the voters as articulated in Proposition 215 by implementing a plan to provide for safe and affordable distribution of marijuana to all patients in medical need of marijuana.

I certify that the foregoing is a full, true and correct copy of a Resolution passed by the City Council of the City of Oakland, California on

Oct 27, 1998

CEDA FLOYD
City Clerk and Clerk of the Council

Per Onetta Middleton Deputy

OAKLAND CITY COUNCIL

RESOLUTION NO. 75713 C.M.S.

INTRODUCED BY COUNCIL MEMBER_____

RESOLUTION RENEWING THE CITY COUNCIL'S DECLARATION OF A LOCAL PUBLIC HEALTH EMERGENCY WITH RESPECT TO SAFE, AFFORDABLE ACCESS TO MEDICAL CANNABIS IN THE CITY OF OAKLAND

WHEREAS, on November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, by a YES vote of 55.7 percent, and the residents of Oakland voted YES for Proposition 215 by an overwhelming 79.3 percent; and

WHEREAS, marijuana has been shown to help alleviate pain and discomfort in people suffering from a variety of illnesses including AIDS, cancer, glaucoma, and multiple sclerosis when no other medications have been effective; and

WHEREAS, the City Council of the City of Oakland finds that many of Oakland's residents are suffering from life-threatening or serious illnesses whose painful symptoms are alleviated by the ingestion of cannabis; and

WHEREAS, there is a need to ensure that patients have access to a safe and affordable supply of medical grade marijuana and cannabis products; and

WHEREAS, the City Council finds that the Oakland Cannabis Buyers' Cooperative has provided a well-organized, safe and responsible opportunity for seriously ill persons to obtain medical cannabis in furtherance of a course of medical treatment; and

WHEREAS, the Oakland City Council passed Resolution 72516 C.M.S. supporting the activities of the Oakland Cannabis Buyers Cooperative and declaring it to be the policy of the City of Oakland that the investigation and arrest of certain individuals involved with the medical use of marijuana shall be a low priority for the City of Oakland; and

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WHEREAS, on October 13, 1998 the federal district court authorized the U.S. Marshal to enforce the aforesaid preliminary injunction by entering the cooperative's premises located at 1755 Broadway in Oakland, evicting any and all tenants and padlocking the doors to such premises; and

WHEREAS, on October 19, 1998, the Oakland Cannabis Buyers' Cooperative voluntarily ceased its operations at 1755 Broadway; and

WHEREAS, the Oakland Cannabis Buyers' Cooperative provided medical cannabis to two thousand two hundred (2,200) seriously ill persons, approximately two-thirds of whom are living with AIDS; and

WHEREAS, the closure of the Oakland Cannabis Buyers' Cooperative impairs public safety by encouraging a market for street narcotic peddlers to prey upon Oakland's ill residents by selling them marijuana that may be contaminated and will be of unknown content and potency; and

WHEREAS, the City Council finds that the closure of the Oakland Cannabis Buyers' Cooperative will cause pain and suffering to seriously ill Oakland residents who are unable to cultivate medical strains of cannabis for their personal use and therefore either no longer

have access to medical cannabis to alleviate their pain and suffering or purchase contaminated cannabis from street narcotic peddlers; and

WHEREAS, on October 27, 1998, the City Council passed Resolution No. 74618 C.M.S. declaring a local public health emergency with respect to safe, affordable access to medical cannabis in the City of Oakland;

NOW THEREFORE, be it

RESOLVED: that the City Council of the City of Oakland finds that a public health emergency exists with respect to access to an affordable and safe supply of medical cannabis, and pursuant to Government Code section 8630 does so declare; and be it further

RESOLVED: that the City Council finds that the thousands of seriously ill persons who obtained medical cannabis from the Oakland Cannabis Buyers' Cooperative will endure great pain and suffering and in some cases may die as a result of the closure of the cooperative and other entities that supplied medical cannabis; and be it further

RESOLVED: that the City Council of the City of Oakland urges the federal government to desist from any and all actions that pose obstacles to access to cannabis for Oakland residents whose physicians have determined that their health will benefit from the use of marijuana and recommended or approved medical cannabis use for such residents; and be it further

RESOLVED: that the City Council urges the Alameda County Board of Supervisors to declare a public health

emergency with respect to access to medical cannabis; and be it further

RESOLVED: that copies of this resolution shall be forwarded to Senators Boxer and Feinstein, Congresswoman Lee, and the President of the United States, William Jefferson Clinton, urging federal policy-makers to dismiss the current lawsuits against California's cannabis buyers' clubs and cooperatives; and be it further

RESOLVED: that copies of this resolution shall be forwarded to Governor Gray Davis, Attorney General Lockyer and all representatives of the City of Oakland in the State Legislature, urging them to comply with the will of the voters as articulated in Proposition 215 by implementing a plan to provide for safe and affordable distribution of marijuana to all patients in medical need of marijuana.

In Council, Oakland, California, May 16, 2000, 1999

PASSED BY THE FOLLOWING VOTE:

AYES- Brunner, Chang, Miley, Nadel, Reid, Russo, Spees, and President De La Fuente - 8

NOES- None

ABSENT- None

ABSTENTION- None

Attest CEDA FLOYD
CEDA FLOYD
City Clerk And Clerk Of The Council Of The
City Of Oakland, California

California Marijuana Arrests, 1930-1999

Source: Cal. Dept. of Justice, Criminal Justice Statistics Center
"Adult and Juvenile Arrests Reported," various years

Year	Misdemeanors	Felonies	Total
1930		228	228
1931		91	91
1935		140	140
1960		5,155	5,155
1961		3,794	3,794
1962		3,743	3,743
1963		5,518	5,518
1964		7,560	7,560
1965		10,002	10,002
1966		18,243	18,243
1967		37,514	37,514
1968		47,939	47,939
1969		51,414	51,414
1970		64,880	64,880
1971		61,199	61,199
1972	3,500	73,061	76,561
1973	3,500	88,110	91,610
1974	3,500	99,597	103,097
1975	3,500	85,757	89,257
1976	34,110	19,284	53,394
1977	34,110	17,262	51,372
1978	35,424	17,397	52,821
1979	32,796	19,263	52,059
1980	38,270	20,509	58,779
1981	43,791	20,771	64,562
1982	42,904	20,737	63,641
1983	43,803	19,926	63,729

1984	42,219	21,350	63,569
1985	43,181	24,182	67,363
1986	30,105	19,938	50,043
1987	32,424	18,722	51,146
1988	27,373	16,853	44,226
1989	25,825	16,325	42,150
1990	20,834	16,819	37,653
1991	19,383	14,050	33,433
1992	22,493	14,980	37,473
1993	25,914	14,357	40,271
1994	31,294	14,668	45,962
1995	35,854	14,449	50,303
1996	41,595	15,361	56,956
1997	43,169	14,498	57,667
1998	46,600	14,344	60,944
1999	48,673	14,171	62,844